This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

**Facts and data about this trust**

**Background**

Weston Area Health NHS Trust provides a wide range of acute and rehabilitation hospital services, as well as some community health services primarily to residents of the North Somerset area. It serves a resident population of around 212,000 people in North Somerset with over 70% of people living in the four main towns of Weston, Clevedon, Portishead and Nailsea. A further 3.3 million day-trippers and 375,000 staying visitors increase this base population each year.

The trust provides clinical services from three sites. The main site, Weston General Hospital, is located close to the town of Weston-super-Mare. There are two children’s centres providing community children’s services located in Weston-super-Mare and Clevedon.

The trust works closely with other hospitals in Bristol as part of ‘clinical networks’ including, for example, cancer, pathology and cardiology.

At the time of our inspection the trust was involved in consultation surrounding an initiative called “Healthy Weston”. Healthy Weston is a programme led by the local clinical commissioning group aimed to join services for better care in Weston-super-Mare, Worle and surrounding areas. This includes the future for services at Weston General Hospital. The consultation period aimed to run until May 2019 at which point the trust would be involved in the review of, and plans for its part in the Healthy Weston programme.

Additionally, to Healthy Weston, the trust has confirmed plans to join with a local NHS trust based in Bristol. The plan is for this piece of work to be completed by the Spring of 2020 with the aim of improving the effectiveness of services offered to the population of North Somerset.
Staff and services

The trust’s workforce, of around 1,800 clinical and non-clinical staff, works primarily on the single hospital site, Weston General Hospital. The hospital has 261 beds, 11 inpatient wards, and 10 beds for day-case surgery. The trust provides full emergency department services for adults and children, and critical care for adults. This service operates under restricted times, currently seeing patients from 8am to 10pm. Patients are admitted for emergency and planned surgery, and a full range of medical care services. There are a range of outpatient services - including Child and Adolescent Mental Health Services (CAMHS), services for older people, acute stroke care, cancer services and a full pharmacy service.

The trust provides maternity services, including a midwife-led maternity unit, community midwifery antenatal care and postnatal care.

Diagnostic services include pathology, CT scanning, X-ray, MRI scanning, ultrasound and interventional radiology.

What people who use the trust’s services say

The NHS friends and family test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

Measuring from January 2018 to December 2018, the trust scored about the same as the England average for recommending the trust as a place to receive care.

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Financial position

The financial position at the trust was challenging. In 2016/17, the trust saw a deficit of £8.9m against an income of £103.8m. In 2017/18, the trust returned a deficit of £14.6m and income that year fell to £101.2m. The trust plan for 2018/19 was to show a loss of £12.4m against a
slightly increased income of £102.6m. For the year 2019/20, the projected deficit has not been provided.

**Is this organisation well-led?**

To write this well-led report and rate the organisation, we interviewed the members of the trust board, both the executive and non-executive directors, and a range of senior staff across the trust. We met and talked with a wide range of all members of staff to ask their views on the leadership, performance and governance of the trust. We looked at a range of performance and quality reports, audits and action plans, board meeting minutes, and papers to the board. We reviewed investigations into serious incidents and deaths, and feedback from patients, local people and stakeholders.

**Leadership**

The trust’s leadership team had the integrity, and a range of experience and capability to manage the organisation. The executive team and the trust’s board members were a group of individuals with a wide and varied range of experience, knowledge and developmental need. We saw, through our conversations with the executive team, the non-executive directors and other leadership groups that there was evidence of a positive and productive working relationship within the team.

The chief executive officer was appointed in the role to the trust in August 2015 having had a number of years of executive level experience prior to this. The chair was appointed to the post in April 2015 having previously served as a non-executive director at the trust.

The medical director had been in post for almost two years at the time of our inspection, and the director of operations also for two years. The director of operations was also the deputy chief executive officer – appointed to this additional role in December 2018. The director of nursing had been at the trust since January 2018, having been appointed on a secondment initially, and made substantive in December 2018. The director of human resources was seconded from a local trust to the role and had been at Weston since January 2018. The finance director was also seconded into post and had been at the trust since April 2018.

We were assured that the leadership team at the trust were fully sighted and conversant with the challenges of their roles. However, at the time of our inspection there were a number of competing priorities for the leadership team which meant that capacity to address all of them adequately was a concern.

The chair and other executives were knowledgeable on the key drivers of the financial position and financial risks. The Chair indicated that most board members understood their role with respect to delivering the financial position. Finance was seen as an organisational issue to address, not just the responsibility of the finance director and the finance team. However, there was still further work to do to make sure this was understood by all staff.

In pharmacy there was a senior leadership team that led and supported the department. However, the team was challenged by a pharmacy workforce that was 50% under resourced when compared with the staffing levels recommended by the Carter Report. The Carter Report was published in 2016 and addressed the issue of staffing and maximising its benefit in NHS organisations. According to these recommendations, the trust needed 44 whole time equivalent staff in its pharmacy team. Data provided to us by the trust stated that had 22.5 whole time equivalent staff. The department had high staff turnover and what was felt to be a lack of internal development. A business case, for additional resource to increase the team capacity to deliver
acceptable rates of medicines reconciliation, was submitted for discussion to the board in April 2019. This paper had the support of the medical director and the director of nursing, but it was not clear if the financial position of the trust allowed for additional recruitment.

**There was a trust board of individuals with different strengths, experience and skills, providing collective leadership.** James Rimmer, the chief executive officer had worked within the NHS for a number of years prior to joining Weston Area Health NHS Trust in 2015. Our conversations with James demonstrated his insight into the strengths and development needs of his board, and his resilience with regards to the challenges this brought.

The non-executive directors, of which there were four in addition to the chair, had been appointed between 2013 and 2018. The trust’s chair, Grahame Paine joined the organisation in 2009 as a non-executive director, taking up his current chair role in 2015. Grahame held roles in a variety of banking institutions until 2005, since which he has held roles in central government, higher education and a number of financial service companies. The four non-executive directors have a variety of clinical and non-clinical backgrounds including finance, health service management, business and nursing. This brings with it the benefit of clinical and non-clinical insight into the challenges of the trust.

Of the six executive roles at the trust, two were filled by seconded post holders. Of the remaining four executive post holders three of these were first time executive roles. This did provide a challenge to the trust in that these post holders were developing into these roles at a time when the trust was facing significant challenge and change.

There was limited ethnic and gender diversity within the board. Of the six executive voting board members at the trust, none were black or minority ethnic (BME), and two were female. Of the six non-executive board members, none were BME and two were female.

**There was a lack of succession planning at senior leadership level although board development programmes were running for development at this level.** There was a lack of formalised succession planning within the trust, with very little flexibility in the event of a vacant role at senior management level. This had been recognised as a need by the director of human resources who had taken a paper to board on the topic of succession planning. There were 11 members of staff who attended a local leadership course, but there was an absence of significant support to the executive team at sub-board level. We saw that support for this issue was being procured through close working relationships with a neighbouring trust, as well as through the use of funding to support some additional posts. However, there remained the challenge of a lack of succession planning to provide any kind of leadership infrastructure which further jeopardised the performance of the trust and presented a risk to the wellbeing of the senior leadership team.

The trust had a board development programme which consisted of more structured “away days” and bi-monthly seminars. The aim of this programme was to improve and maximise the ability of the board to scrutinise the performance of management, monitor the reporting of performance, and satisfy themselves as to the integrity of financial, clinical and other information.

**The trust did not always meet its obligations to ensure directors were fit and proper persons.** The trust could not be assured that all staff with director level responsibilities, including the non-executive directors, were fit and proper persons in accordance with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (FPPR).

To assure the trust it’s directors met the test, the trust required each director to complete a self-declaration. However, these had not been counter-signed by another person or ratified on the form by the trust chair. The trust’s policy on fit and proper persons said, “The Chair of the Trust via the Trust Board Secretary will be responsible for confirming to the CQC and NHS
Improvement that a new director is a fit and proper person.” However, there was no evidence as to how this was achieved or declared, and the policy did not say what evidence should be provided.

We examined the records of the trust for its FPPR declarations, examining the records of both the executive and non-executive board members. However, we were not able to examine the files of the human resources director or finance director due to their seconded roles, and the trust kept no record of this. The trust could not therefore be assured that these individuals met the requirements of the fit and proper persons test. For the files that we were able to examine there was varying amounts of evidence available to establish that they had met the requirements of the fit and proper persons test. Some files contained a “due diligence pack” and where this was the case we could see clearly records of checks against things such as the insolvency register and other checks necessary as part of the fit and proper persons test. However, not all files we examined had these packs and where they were lacking there were gaps in supporting documentation. For example, we could not see a record of insolvency checks for the chief executive officer in his personal file. For the chairman, we could not see any record or checks against the register of barred directors.

Leaders at senior levels were not always visible, approachable or supportive of their staff. During our inspection we heard a lot about the numerous directions the executive and non-executive teams were pulled in the delivery to the local sustainability and transformation plan (STP), to Healthy Weston and to the planned joining of the organisation with another local trust. This had inevitably led to less focus internally at the trust while they met the demands of the system in which they operated. The result of this, when we spoke with staff was that they felt disconnected from the senior leadership team, and less confident to approach them. It was not felt that the executive or non-executive team made themselves available to staff and the resultant disconnect was felt personally by staff. However, we did hear about “Ward Wednesday” an initiative introduced to ensure the director of nursing was available on a regular basis to staff at all levels. This initiative saw the director of nursing wear uniform and be present in clinical areas every Wednesday as well as being able to provide quick answers to questions when needed. We heard mixed feedback about the reach of this initiative, and how effective it was at contacting those staff who may benefit from it.

At sub-board level, clinical leadership provided a mixed picture with regards to visibility, availability and approachability. Within the surgical division, we heard that in the main, leaders were approachable and available. However, within the emergency division this was not often felt to be the case with leadership of these divisions felt to be unapproachable and unhelpful.

At local level, we heard that leaders were helpful, knowledgeable and approachable in the main. During the core services inspection we witnessed caring leaders at local levels providing support to their teams. We heard how staff felt able to discuss issues with their local ward sisters for example and felt assured of the support they would receive.

In the 2018 NHS staff survey, the trust performed worse than the national average for NHS acute trusts in all indicators relating to managers, although some had seen improvements. When staff were asked in the 2018 survey if they knew who the senior managers were, 74% said they did (this was marginally up from 73% the previous year). The national average was 83%.

In other questions relating to managers and the leadership, 39% of staff agreed or strongly agreed the organisation recognised the work of staff (up from 35% in 2017). The national average for 2018 was 46%. Support from immediate managers was responded to positively by 64% of staff (up from 58% in 2017). The national average was 69%, so although both indicators
had improved from the previous year, both were below the national average for acute trusts. Other indicators around relationships with managers included these, all of which were below (worse than) the national average:

- 26% of staff agreed or strongly agreed that communication between senior management and staff was effective – 15% below (worse than) the national average. This was a 1% improvement over 2017.
- 70% of staff agreed or strongly agreed their immediate manager was supportive in a personal crisis – 4% below (worse than) the national average. This was a 1% improvement over 2017.
- 68% of staff agreed or strongly agreed their immediate manager valued their work – 3% below (worse than) the national average. This was a 6% improvement over 2017.
- 64% of staff agreed or strongly agreed their immediate manager can be counted on to help them with a difficult task at work – 5% below (worse than) the national average. This was a 1% improvement over 2017.
- 24% of staff agreed or strongly agreed senior managers tried to involve staff in important decisions – 10% below (worse than) the national average. This was the same as 2017.
- 54% of staff agreed or strongly agreed their immediate manager gave them clear feedback on their work – 6% below (worse than) the national average. This was a 1% improvement over 2017.
- 23% of staff agreed or strongly agreed senior managers acted on staff feedback – 9% below (worse than) the national average. This was a 3% improvement over 2017.

The leadership team recognised there were challenges to high quality care and sustainability. During our interviews with the senior leadership team we were assured there was a common recognition of the challenges facing the organisation and its ability to provide high quality care in a sustainable way. Notwithstanding the financial challenges which were sizeable and commonly articulated by the leadership team, the trust also faced a number of other pressures on the capacity of the leadership team. Within the local system, there was greater scrutiny of the trust – requiring a higher than usual level of reporting.

Additionally, the trust was operating under greater scrutiny from other bodies such as the General Medical Council, and Health Education England. Combined with the work around “Healthy Weston” and the planned joining with another trust in 2020 the sheer volume of challenge this created to capacity alone was clearly understood by the leadership team. The leadership team were not able to provide any plans or assurances for how this capacity issue was to be managed, and it didn’t feature on the risk register of the trust. This was also reflected in the documents we read including the board and subcommittee papers. However, it was clear to see that patient experience formed the focus of management of these challenges with the effects of such felt very much on the staff side of the equation. All senior staff we met demonstrated a commitment to providing safe, high-quality care with the right outcomes for patients, and they understood the challenges to this.

Vision and strategy

There was a clear interconnected vision and strategy for the trust which recognised quality alongside sustainability. The trust articulated a clear vision which was, “To work in partnership to provide outstanding healthcare for every patient”. This vision was supported by the trust’s values which aimed to guide actions, behaviours and decision making within the trust. The
values were articulated as PRIDE: People and Partnership – working together with colleagues, other organisations and agencies to achieve high care standards or specifically helping a service user, visitor or colleague. Reputation – actions which build and maintain the Trust’s good name in the community. Innovation – demonstrating a fresh approach or finding new solutions to problems. Dignity – Contributing to the Trust’s Dignity in Care priorities. Excellence and equality – demonstrating excellence in and equality of service provision.

The vision sat alongside a strategy that aimed to move the organisation from a model of independent service provision to one of formal partnership working. The strategy was developed over a period of months using board seminars and including patient and staff involvement. The trust told us that the strategy focused on the "place" of Weston and sought, through partnerships, to maximise the widest appropriate range of local services, improve clinical sustainability, deliver high quality healthcare, meet national performance indicators, deliver economies of scale and support system stability.

A revised business model to deliver this was established, with a five-year plan running from 2016 to 2021. The plan had articulated three clear stages over the five years; delivery, transformation and sustainability. At the time of our inspection the trust told us they were in the transformation stage. The trust board reviewed the strategy annually to monitor progress. The themes were embedded into the trust operating plan, which was monitored quarterly through the senior management committee and trust board. In the most recent trust board review, the strategy was confirmed as still live and relevant to current work and progress against original ambitions was noted. Priority projects such as the Healthy Weston Programme were supporting the transformation that was needed to occur to improve the clinical and financial sustainability of the organisation. The vision was confirmed as still relevant and accurate for what the trust wanted to achieve. The trust had strong engagement with the local health and social care community, through the commissioner-led “Healthy Weston Programme” and was working to develop its links with local primary care.

However, pharmacy and medicines optimisation were not integrated into trust strategy. In the overall trust strategy (2016-2021) pharmacy was only mentioned once on the final page under weaknesses “Pharmacy delays causing blockages to discharge”. We were not therefore assured
that the challenges faced by the pharmacy department were given a high enough profile to drive
improvement.

There was no medicines optimisation strategy. The hospital pharmacy transformation plan
(HPTP) was written in July 2017. The transformation plan consisted of five main projects:

- reviewing the current pharmacy infrastructure
- reviewing the current pharmacy skill mix
- reducing unwarranted variation in medicines costs
- expanding the range of clinical pharmacy services available
- extending the supply and clinical pharmacy services to cover 7 days

There was little evidence of improvement made in any of these areas. No significant changes
had been made to pharmacy infrastructure. However, early discussions were underway about
shared planning, stores and production with the pharmacy department of another local trust. The
pharmacy department was significantly under resourced, although they had just recruited a band
8a antimicrobial and intensive care pharmacist. This limited the clinical service delivered by
pharmacy and meant the department was reactive to issues and focussed on supply.

The trust was working alongside the local area strategy for achieving the priorities and
delivering good quality sustainable care. The trust was working collaboratively with the local
system to put itself at the centre of an integrated healthcare delivery model designed to meet the
needs of the local population. The trust’s own strategy was aligned with local plans for delivery of
care in the wider health and social care economy. The trust was working actively to develop
relationships in the community and with local trusts, as well as with partners and stakeholders to
drive the goal of providing better integrated care in Weston and surrounding areas. The trust had
a partnership agreement in place and this relationship was evolving over time. A clinical practice
group (CPG) model was being used to bring together clinical leaders to take their services
forward, working without organisational barriers to achieve improvement through removing
clinical variation and delivering efficiencies. Orthopaedics was given as an example of one of the
services involved in this model and feedback from divisional managers was generally positive on
CPG’s.

The trust was a key stakeholder in the development of “Healthy Weston”, a clinical
commissioning group programme which aimed to improve healthcare services in Weston and the
surrounding areas. The vision of this programme was for clinical teams at the trust to work more
closely with colleagues in primary care and the community as well as with those providing social
care services. The programme was framed by the wider “NHS Five Year Forward View” and the
more recently published “NHS Long Term Plan”.

The processes for cost improvement programme (CIP) identification, development and
monitoring were well articulated during interviews. CIPs are used as a tool that promotes best
practice in identifying, delivering and monitoring cost improvement programmes in the NHS.
However, delivery had been poor in 2018/19 both of the original CIP and the financial recovery
plan. At the time of our inspection there wasn’t a pipeline of future CIPs in development, but this
was identified by the trust as an area for focus going forward. Steps had been taken to enhance
CIP processes including seconding an experienced CIP accountant from a local trust to provide
additional capacity and rigor to the planning and monitoring processes.

Culture

The culture of the organisation was centred on people who used services. The values and
vision for the trust placed people who used the services of Weston Area Health at the centre. The
vision of the trust talked of “providing outstanding healthcare to every patient”. However, what we
saw during the inspection was that the drive to put the patient at the centre of the service often meant that the impact of challenges was felt at the staff side of the equation. Additionally, patients’ medicines needs were not supported at discharge. Medicines were supplied at discharge without counselling, from nurses or pharmacy staff. Most complaints received about the pharmacy service related to discharge procedures.

All staff felt proud to work for the organisation but not all were positive about the experience of doing so. During the inspection of core services, and our well-led inspection, we met and talked with a wide range of staff. This included senior leadership teams, all levels of medical staff, matrons, sisters, and other patient facing front line staff. All the staff we met with at all levels were proud of the contribution they made to the organisation and regarded their work as important. Some staff spoke of the benefits of working in a small hospital and said it made it a friendly and supportive place to work. However, a significant proportion of people we spoke with at operational levels commented that the culture of the organisation made it difficult for them to feel positive about their work, or confident in their ability to carry out their role. It was felt that the culture of the organisation had failed to improve for a number of years, and that this was not recognised or acted upon by senior leaders. We heard of a number of examples of staff feeling bullied, undermined or humiliated with a fear of retribution or inaction if they spoke out. We brought this to the attention of the chief executive officer who took swift action to organise an independent investigation into the statements we received.

The trust had a workforce strategy, drafted in August 2018, which contained an objective that stated, “Embedding the vision and values of the Trust to secure increased levels of staff engagement and satisfaction.” However, this had not appeared to achieve this aim at the time of our inspection with a continuing challenge around the retention of staff. Although staff survey results were marginally improved they still performed consistently below the national average. There was planned work at the trust to address culture in line with the work carried out by the King’s Fund. This work recognised that healthy cultures in NHS organisations are crucial to ensuring the delivery of high-quality patient care. The Kings Fund project developed a tool to help organisations assess their culture, identifying the ways in which it is working well, as well as the areas that need to change.

Pharmacy staff felt that the trust senior leaders were unaware of the pharmacy workload and the additional patient facing services that could be offered, with additional staffing. They called themselves a “hidden service”.

A group of nursing staff with supervisory responsibilities we met with, felt that the commitment to carry out the large remit of their roles often compromised their capacity to listen to their staff and act on their concerns. They were clearly troubled by this and stated that they felt they were given responsibility but no power over their working lives. There was a feeling amongst staff that it was the commitment to patients that kept them motivated rather than a commitment to the organisation.

Actions were not always taken to address behaviour and performance inconsistent with the values. The values were not always exhibited by leaders. We raised feedback we had received from staff, about the behaviours and performance of clinical leadership, with the executive leadership straight after our core services inspection. The trust acted swiftly to appoint an external investigator to explore the issues with a view to managing these swiftly and we were assured by the competent way in which this was managed. However, we heard while we were on both the core services and well led inspection of a feeling of disparity between the way in which poor performance was managed at different levels. The perception articulated to us by a variety
of staff was that those staff whose roles sat below clinical leadership had poor performance managed differently to those who sat within clinical leadership roles and above.

Not all staff in leadership roles demonstrated they had the competencies required to follow the trusts’ policies and processes in the management of poor performance or behaviour. We heard of examples whereby the trust’s values were not displayed by clinical leaders in the management of poor performance. This sat alongside a climate where stress related absences from work continued to increase.

Staff survey results suggested that the workforce at the trust did not always feel it was positive place to work, or that they received the respect they deserved from colleagues. The trust, overall, had disappointing 2018 NHS staff survey results around culture, with key indicators being below (worse than) the national average for acute trusts, although some improving. This was coupled with a poor and reduced response rate in 2018. The key indicators around culture included:

- 53% of staff agreed or strongly agreed they would recommend the organisation as a place to work. This had improved from 46% in 2017. It was, however, 10% below (worse than) the national average.
- 37% of staff agreed or strongly agreed that they often thought of leaving the organisation. This question was not asked prior to 2018. The response was 7% above (worse than) the national average.
- 67% of staff said they agreed or strongly agreed that they received the respect they deserved from colleagues at work. This question was not asked prior to 2018. The response was 4% below (worse than) the national average.
- 86% of staff agreed or strongly agreed their role made a difference to patients. This was the same as in 2017, but 4% below (worse than) the national average.

The trust was below (worse than) average among NHS acute trusts for numbers of staff who responded to the survey. The survey was sent to all staff, and 627 (37%) responded (the national average for acute trusts was 44%). This was down from the 45% of staff who responded in 2017.

Fewer staff than the NHS average for acute trusts felt there was an emphasis on the safety and wellbeing of staff. In the 2018 NHS staff survey, just 21% of staff agreed or strongly agreed that the organisation took positive action on health and wellbeing. This was a decline from 22% in 2017 and 7% below (worse than) the 2018 national average of acute trusts of 28%. However, 63% of staff agreed or strongly agreed that their manager took a positive interest in their health and wellbeing. This was better than 2017 (59%) but below (worse than) the national average (67%).

The following results around work pressures were above (worse than) the national average, and they describe many staff with these negative experiences:

- 41% of staff said they had felt unwell due to work-related stress in the last 12 months. This had slightly improved since 2017 (43%) but was slightly above (worse than) the national average of 39%.
- 22% of staff said they had felt pressure from their manager to come to work. This had marginally improved since 2017 (24%) but was above (worse than) the national average of 19%.
59% of staff said they had attended work in the last three months despite not feeling well enough to perform their duties. This had marginally improved since 2016 (60%) and was above (worse than) the national average of 57%.

The trusts workforce strategy identified staff health and wellbeing as an objective, with key measures against the success of its delivery. However, some of the actions of the objective talked of continuing with certain actions, and others were less clear in how they connected with the objective. For example, “Continue to promote the importance of the monthly PRIDE values”, and “Publish a programme of events for staff to access internally and externally”. It was not clear how these actions would impact those parts of the staff survey highlighted as performing poorly in regards staff health and wellbeing.

The trust had performed well however in the uptake of the influenza vaccination. 80% of staff at the trust had received the vaccination, which placed the organisation sixth in the Southwest region.

The trust also employed bullying and harassment ambassadors who were available to support staff who were subject to this behaviour.

There were some staff who had experienced physical violence, harassment, bullying or abuse from staff, patients or members of the public, but a relatively good number were reporting this. The number of staff who had experienced harassment, abuse and bullying was either slightly worse (when it was experienced from patients, relatives or the public) or better (when it was experienced from other staff) than national averages.

The 2018 NHS staff survey results reported 20% of staff (same as the national average) had experienced harassment, abuse and bullying from other staff at the trust. Sixteen percent said they had experienced this from managers, which was 2% above (worse than) the national average. Both had slightly improved from the 2017 staff survey response. However, the number of staff reporting the most recent experience had fallen from 49% in 2017 to 41% in 2018. This was below (worse than) the national average for 2018 of 44%. Other key findings included:

- 18% of staff (21% in 2017) had experienced physical violence from patients, relatives or the public in the last 12 months. This was slightly above (worse than) the national average for acute NHS trusts of 14%.
- 69% of staff (66% in 2017) reported the most recent experience of violence. This was above (better than) the national average of 66%.
- 29% of staff (36% in 2017) had experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months. This was the same as the national average of 28%.

As required, junior doctors were supported by a senior doctor known as the ‘guardian of safe working hours’. The trust had appointed a guardian of safe working hours to provide assurance to the trust board, the General Medical Council and Health Education England that doctors in training were safely rostered with access to education and training. Furthermore, their working hours should be reported as compliant with their terms and conditions of service. The guardian was required to raise concerns to the trust board and potentially to external bodies if this was not the case.

We met with the current guardian who, as required, was a senior doctor within the trust, and independent from the management structure. They had been in the post for two years. A report was presented to the board on a quarterly basis which highlighted several elements of the doctors’ contract, including exception reports. Sometimes this was presented by the guardian,
and sometimes by the medical director. We reviewed the report which covered August 2018 – October 2018. This demonstrated that the exception reports made in this time period were all centred on working hours rather than any lost educational opportunities. There was not a significant variation in the number of exception reports between the two divisions at the trust. The report also included a summary of the corresponding junior doctor forums which provided assurance that the board was sighted on the experiences of this group of staff.

When we met with junior doctors they demonstrated a good grasp and a positive experience of the role of the guardian of safe working hours. The junior doctors we met with were clearly hard working, engaged and committed to their role. They reported a mixed picture of confidence in speaking up which was dependent on their areas of work, and also mixed feedback about the support they received from consultants – again dependent on their area of work at the trust.

Equality and diversity were promoted within the organisation and most staff we met felt they had equal treatment. The trust had an equality forum which was a non-statutory forum established by the people and organisational development (POD) Committee. The purpose of the forum was to support and, where appropriate, take action to enable the mainstreaming of equalities and inclusion in all of the trust’s activities. The group met bi-monthly and produced reports to be presented at board with the aim to ensure the board was sighted on equality and diversity activities or issues in the trust.

Staff we met said they did not feel they were treated any differently on the grounds of any protected characteristics.

The trust was not publishing the information required to support equality and diversity.

Equality Delivery System (EDS2)

The NHS England website stated that EDS2 became mandatory from April 2015 and was a requirement of all NHS provider organisations. The trust did not provide this information to us, or publish it on the website. It did however publish its goals and outcomes against these standards, but this document was not dated and so it was not possible to measure the trust performance over time with regards to EDS2.

Workforce Race Equality Standard

In the 2018 staff survey, the experiences of staff from a black or minority ethnic (BME) background provided a concerning picture at the trust, compared with their white colleagues. There had been a deterioration in the experience of harassment, bullying or abuse from patients, relatives or member of the public, as well as the number of BME staff who believed that they did not have equal opportunities for career progression or promotion. Additionally, there had been deterioration in the percentage of BME staff who experienced discrimination at work from a manager or other colleague. The table below provides the findings in detail:
Of the four questions above, BME staff at the trust reported a worse experience than white staff in all answers.

- 42.9% of BME staff experiencing harassment, bullying or abuse from patients, relatives or members of the public in the last 12 months. This result had deteriorated since the 2017 survey when 24% of BME staff experienced this. The 2018 result was higher (worse than) the 2018 England average for BME staff in acute trusts of 29.9%.
- 26.5% of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months. This result had deteriorated from the 2017 survey when 23% of BME staff experienced this. The 2018 result was above (better than) the 2018 England average for BME staff of 30.1%.
- 53.8% of BME staff believed the trust provided equal opportunities for career progression or promotion. This result had deteriorated since the 2017 survey where 82% had answered yes to this question. This was significantly below (worse than) the 2018 England average for BME staff of 69.8%.
- 16.7% of BME staff had personally experienced discrimination at work from a manager/team leader or other colleagues. This result had deteriorated from 2017 when 7% of BME staff reported discrimination. This was above (worse than) the 2018 England average for BME staff of 15.9%.

Importantly, for all four questions, the difference between the experiences reported by BME staff and white staff was worse than for staff across all acute trusts in England.

To put this into context, 92% of staff identified themselves in the 2018 NHS staff survey as white. Of the 605 staff who responded, 49 staff identified themselves as non-white. The national average for acute trusts for staff identifying themselves as white in 2017 was 87%.

The trust complied with NHS England’s requirements to complete and publish a Workforce Race Equality Standard (WRES) survey. The most recent report was the latest version of the required data.

The trust and its staff recognised the need to be able to speak-up, and had effective arrangements for the role of the speak-up guardian. The trust had responded to the requirement to appoint a freedom to speak up guardian, and there were an additional three speak up ambassadors. Speaking up related to the need for NHS workers to raise concerns about their work. Workers may wish to speak up about concerns that are big or small and may, or may not relate to the safety of patients or staff.

The need to provide better support for NHS workers to raise concerns was highlighted in the Francis Freedom to Speak Up Review, published in February 2015. The review was set up in
response to evidence that NHS organisations did not appropriately react to the concerns raised by staff, including the maltreatment of those speaking up.

We spoke with the trust’s freedom to speak up guardian who could articulate clear arrangements for the role, and the three ambassador roles within the trust. The freedom to speak up guardian had good access to the senior leadership team, and take up of the freedom to speak up service was high relative to the size of the organisation. However, pharmacy staff were aware of the freedom to speak up guardian role, but were not clear who this individual was or how to report concerns to them.

The freedom to speak up guardian clearly had a sound understanding of the issues faced by staff in the trust; themes and challenges as well as an accurate reflection of the difficulties faced by the executive team in responding to such themes and challenges. The guardian presented a quarterly report to the board, during the public board session and felt that the challenge faced at these meetings contributed to an effective speak up process.

Not all staff were confident about reporting unsafe clinical practice or in the response of the organisation. The 2018 NHS staff survey results in this area were mostly below (worse than) the national average for acute trusts, but marginally better in some areas than 2017. In the 2018 NHS staff survey, 87% of staff agreed or strongly agreed the organisation encouraged reporting of errors, incidents or near misses. This was, however, marginally worse than the national average for acute trusts of 88%. It was the same as the 2017 score for the trust. This measure came from a series of more detailed questions, which had varied responses:

- 94% of staff said they knew how to report unsafe clinical practice. This was the same as the national average.
- 49% of staff said they agreed or strongly agreed the treated staff who were involved an error, incident or near miss fairly. This was 10% below (worse than) the national average, and the same as in 2017.
- 59% of staff said they agreed or strongly agreed the organisation acted to ensure errors, incidents or near misses did not happen again. This was 11% below (worse than) the national average, although a rise of 1% over 2017.
- 66% of staff said they would feel secure raising concerns. This was slightly below (worse than) the national average of 69% and the same as in 2017.
- 50% of staff said they were confident the organisation would address their concern. This was below (worse than) the national average of 57%, although 5% improved over 2017.

NHS Staff Survey 2018 results – Summary scores

The following illustration shows how this provider compares with other similar providers on ten key themes from the survey. Possible scores range from one to ten – a higher score indicates a better result.
There were mechanisms for providing staff at all levels with the development they needed, including appraisals. However, the trust was not meeting its internal target for appraisals, although this was improving. The trust target for appraisals (annual performance reviews for staff) was to be above 85% of staff being compliant. In the 12 months from February 2018 to January 2019 (the most recent data at the time of writing) the trust had not met the target in any one month. However, the compliance had improved from 71% in February 2018 to 75.4% in January 2019, so the trajectory was in the right direction. The 2018 NHS staff survey said appraisal rates were much the same as the previous year.

In the 2018 NHS staff survey, 84% of staff said they had an appraisal in the last 12 months. This was 2% below the national average for acute trusts. In other measures related to appraisals:

- 20% of staff said their appraisal helped them to improve how they did their job. This was up 3% from 2017, but 3% below (worse than) the national average.
- 33% of staff said their appraisal helped them agree clear objectives for their work. This was up 3% from 2017, but 2% below (worse than) the national average.
- 28% of staff said their appraisal left them feeling their work was valued by the organisation. This was up 3% from 2017, but 4% below (worse than) the national average.
- 30% of staff said the organisation’s values were discussed as part of the appraisal process. This was up 4% from 2017, but 5% below (worse than) the national average.
Mandatory training was failing to meet internal targets. The trust target for mandatory training was to be above 90% of staff being compliant. In the 12 months from February 2018 to January 2019, the trust had not met the target in any one month. However, the compliance had marginally improved from 82.1% in January 2018 to 83% in January 2019, so the trajectory was in the right direction. It had also not fallen below 80% in any one month. We met with the leads for learning and development in the trust and heard about how these improvements were being achieved. There had been a concerted effort to look creatively at ways of enabling staff to be freed up to attend training. There was also the issue of ascertaining proof of attendance when staff attended training provided externally. This had had the effect of providing data that was not an accurate reflection of training attended although this was an improving picture.

Sickness absence was comparatively low. The trust’s sickness absence levels from October 2017 to January 2018 were higher than the England average however since January 2018, sickness rates had dropped and have consistently been lower than the England average.
Staff turnover and vacancy rates were high when set against the trust’s target levels. In January 2019 (the most recent data at the time of writing), the turnover of staff was reported as 16.8% against a trust target of ≤15%. The average for the 13 months from January 2018 to January 2019 was 17% and the trajectory was showing the rate falling slightly over time. However, despite the high turnover rate, the trust was reporting a vacancy rate of 13% in April 2019 which was below the 12-month average.

General Medical Council – National Training Scheme Survey

There were four areas of concern from 13 within the results of the latest GMC survey. In the 2018 General Medical Council survey, the trust performed worse than expected for four indicators and the same as expected for the remaining nine indicators we report on. This was a clear improvement over the results from 2017 where the trust was worse than expected on eight of the 13 indicators we list.

<table>
<thead>
<tr>
<th>Survey area</th>
<th>Rating 2018</th>
<th>Rating 2017</th>
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<tbody>
<tr>
<td>Overall satisfaction</td>
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<tr>
<td>Clinical Supervision</td>
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<td>Supportive environment</td>
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(Source: NHS Digital)
Governance

There were structures, processes and systems of accountability to operate a governance system designed to monitor the service and provide assurance. The trust held public and private board meetings every month and published minutes and papers from each public meeting on its website. There were a range of committees reporting into the board – each overseen by either the trust chair or one of the non-executive directors (NED) which aimed to provide oversight to the board of the work of the trust. There were six committees in total.

The audit and assurance committee reviewed the assurance framework, financial control systems and received regular reports from the internal and external auditors. The quality and safety committee reviewed the systems, process and practices in place to keep patients safe – ensuring that lessons were learned when things went wrong. The people and organisational development committee reviewed staff numbers, competence, feedback and wellbeing – ensuring that processes to support the workforce were in place and effective.

The finance and performance committee provided a forum where detailed consideration is given to the major financial issues facing the Trust. The remuneration and terms of service committee made recommendations to the trust board on the remuneration and terms of service of directors and senior managers, taking into account comparative data from other trusts. The charitable funds committee was where the trustees for the charitable funds held by the trust met to discuss the charitable funds collected and spent.

There was an annual review process to check the effectiveness of board committees and one of the NED chairs was able to articulate the changes made to membership because of such a review. The chair considered the effectiveness of the board at the end of each board meeting.

The executive and non-executive team evaluated an integrated performance report at the monthly board meeting. However, there was a lack of statistical process control to enable the leadership team to analyse performance in a proactive way. This meant that the reports provided for analysis of past performance, but did not create a space to enable the forecasting of future activity.

Pharmacy sub-groups reported to a drugs and therapeutics committee (DTC), chaired by a consultant rheumatologist. DTC was two steps away from board level and the chief pharmacist was not involved in escalating issues from clinical effectiveness committee to quality and safety committee. Since January 2019 the chief pharmacist had been attending the senior management group meeting and felt pharmacy was better represented. The trust had a medicines safety officer who investigated and reported on medicines incidents. Patient group

<table>
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<th>Work Load</th>
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<td>Educational Supervision</td>
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<td>□</td>
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<tr>
<td>Feedback</td>
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<td>□</td>
</tr>
<tr>
<td>Local Teaching</td>
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<tr>
<td>Regional Teaching</td>
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<tr>
<td>Study Leave</td>
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(Source: General Medical Council National Training Scheme Survey)
directions (PGDs) were updated and reviewed at DTC.

The trust was not fully compliant with the recommendations in the Department of Health report on Homecare Medicines (Hackett report). Homecare prescriptions were not clinically checked and processed through the pharmacy. There was no data to allow accurate horizon scanning on future expenditure and an inability to monitor the extent of switching to biosimilar drugs meant expenditure per activity unit was significantly higher than peers in the model hospital dashboard.

There was insufficient emphasis on financial governance and ownership of those areas of concern the trust could influence. We were informed during interviews with senior finance staff, that the nature of the engagement from non-executive directors (NED) was one of enquiry to gain understanding of the financial position rather than one of challenge or holding individuals to account. We discussed scrutiny of the financial position particularly the recent decline with the NED chair of the committee and weren’t able to see that the committee went beyond understanding the financial position to challenging the executive team on the steps needed to improve it. We concluded the board’s and finance and performance committee’s scrutiny and understanding of movements to the financial position had been limited and should have been more timely and effective given the scale of deterioration from financial plan during 2018/19.

Staff at all levels were clear about their roles and understood what they were accountable for. We met a wide range of staff with differing managerial remits, as well as the full range of front line operational staff. As a smaller organisation there was a reasonably flat leadership structure, with leaders at sub board level and above often responsible for multiple areas of work. However, staff we met were clear about their roles, what and who they were accountable for.

The trust recognised, acted upon and met its legal obligations to safeguard those people at risk from abuse, neglect or exploitation. However, capacity affected the ability to be assured of the effective implementation of safeguarding processes. The trust had appointed named nurses for safeguarding adults and children and a named doctor for safeguarding children. Safeguarding governance was reported to board quarterly via the quality and safety committee. The safeguarding lead also reported quarterly to the clinical commissioning group. Additionally, the trust provided representation at the North Somerset Adult Partnership Board, and the North Somerset Local Children’s Safeguarding Board. PREVENT returns were reported to NHS England quarterly. Annual safeguarding surveys were carried out, with audits throughout the year to evaluate performance. The trust worked within North Somerset information sharing polices. Any risks relating to safeguarding were recorded on the safeguarding risk register and reviewed at the bi-monthly risk management meetings.

Female genital mutilation, the PREVENT strategy and exploitation were well-embedded in training and practice. However, the trust was failing to achieve its target for achievement of safeguarding training, although this was an improving picture at the time of our inspection. Some safeguarding training was provided by external providers and we heard this could cause difficulties gaining assurance that the quality of the training met the needs of staff.

We reviewed the annual safeguarding report for 2017/2018. This report detailed the volume and type of activities relating to adult and child safeguarding at the trust and was comprehensively written. The report contained both contextual information and data related to training uptake and challenges to this.

It was clear that the safeguarding leads were competent in the role, and conversant with the challenges faced by the trust in relation to safeguarding. The biggest challenges centred on capacity. For the safeguarding team this manifested itself in the struggle to provide safeguarding supervisions to teams, and to be assured that safeguarding was working effectively in the trust.
For example, although data showed that the number of referrals to the local authority resulting in action was positive, the team had few methods to assure themselves that all cases that should be referred were being completed. For the children’s lead, this was mitigated by reviewing all the records of children attending the emergency department to ensure these were referred. This was labour intensive but felt to be the only way to mitigate the risk. For the operational staff, capacity challenges that affected safeguarding related to releasing staff to attend training, or capacity to fully engage with the safeguarding leads. Following our inspection, the trust informed us that a further safeguarding practitioner role had been agreed in April 2019.

There was reporting upon the number of complaints and how they were managed, and the annual report to the board committee focused on the quality of complaints management as well as on numbers. The 2017/2018 annual complaints report reported on the responsibilities within the organisation for the management and monitoring of complaints. The report stated the trust board had an overview of trends identified in contacts with the patient advice and liaison service (PALS), which was reported on a bi-monthly basis. In the 2017/18 year, there had been 238 formal complaints made to the trust. This was a decrease from the 251 made in the previous year. The trust had a target of acknowledging complaints within three working days of 100%.

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>40</td>
<td>73.3%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>n/a</td>
<td>n/a</td>
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(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)

The annual report stated that delays in responding were caused by the complexity of the cases and the prolonged investigation time. This led to the creation of the patient safety facilitator role which aimed to improve the quality and timeliness of investigations. Changes had also been made to the way in which the directorates managed complaints.

Another measure of how well a complaint was responded to was how many were reopened. In the 2017/2018 year. However, the annual report did not articulate the numbers of complaints reopened in the 2017/2018 year.

If a patient or member of the public was not satisfied with the response to complaints, they were entitled to contact the Parliamentary Health Service Ombudsman (PHSO) to seek further resolution. Three complaints were registered with the PHSO in the year 2017/2018.

The trust received a high number of compliments for the care of its staff. From December 2017 to November 2018, the trust received a total of 658 formal compliments. The majority were for medical care and the urgent and emergency service, and then surgery. All the services at the trust had been complimented at some point by patients and carers.

The trust encouraged openness and honesty at all levels of the organisation in response to serious incidents. The duty of candour is a regulatory duty that relates to openness and
transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff at the trust were trained from induction onwards to understand and recognise the duty of candour. This approach was amongst the best we have seen and was clearly having a positive impact. Following an internal audit review, the governance team were introducing and embedding new incident training which included duty of candour across the trust, commencing from August 2018. This consisted of three-hour sessions with ongoing peer support. It was aimed at any staff member that may report or handle an incident.

A peer support group was created with the aim of embedding patient centred duty of candour across the trust, through a hands-on supportive approach.

In the year August 2017 to July 2018, the trust had applied duty of candour on 34 occasions. The majority of these applied to medical care (19), which was the largest service at the trust, followed by Surgery (13). The remainder fell into either the emergency department or critical care. Those examples we saw of how duty of candour was applied followed guidance and policy. Staff we met said they recognised the need to be open and honest with patients and their families.

The patient’s voice was heard at some board meetings. Many NHS trusts and community interest companies (delivering NHS contracts) in England have introduced ‘patient stories’ at the board meeting. These are often derived from complaints and concerns, so the board hears directly from patients or carers who had cause to complain. They can also come from positive experiences. As part of our ongoing monitoring of the trust, we attended a number of board meetings throughout the year prior to our inspection. Patient stories were presented at two of the meetings we attended. These stories were used and reviewed by the patient experience review group overseen by the Quality and Safety Committee and a six monthly review of complaint themes is also generated.

Management of risk, issues and performance

The operational performance at the trust was meeting some of the national targets or standards for treating patients. It was performing better than the England average in some measures, particularly referral to treatment times.

Accident and emergency

The trust was not meeting the NHS four-hour target. However, although the accident and emergency department (A&E) was closed overnight, the trust had performed better than the England average against the national four-hour target to admit, transfer or discharge at least 95% of patients attending the department (A&E). However, it had not achieved the target in, for example, the 2018/19 year to January 2019 (the most recent data published).

Results were against a relatively steady number of A&E attendances with the trust seeing around 140 patients per day in the period April to December 2018, with a rise in the summer months likely to relate to visitors.

The results of the 95% four-hour target shown against the England average since April 2018 are below. This includes the last published NHS data for January 2019 for type 1 (A&E admissions, so excluding any minor injury units in a hospital trust) showed:

- Quarter 1 2018/19 (Apr to Jun 2018) – 91.5% (England 84.4%)
- Quarter 2 2018/19 (Jul to Sep 2018) – 89.1% (England 83.5%)
- Quarter 3 2018/19 (Oct to Dec 2018) – 82.7% (England 81.2%)
Referral times for treatment

The trust had been performing well above average for the NHS referral to treatment time target and meeting the standard overall. For example, the trust had met the 18-week referral to treatment standard for incomplete pathways (patient waiting to start treatment) for at least 92% of patients in the last six months (August 2018 to January 2019):

- August 2018 – 92.1%. England average – 87.2%
- September 2018 – 92.9%. England average – 86.7%
- October 2018 – 92.5%. England average – 87.1%
- November 2018 – 92.4%. England average – 87.3%
- December 2018 – 92.8%. England average – 86.6%
- January 2019 – 92%. England average – 86.7%

Looking at the latest published data (January 2019) in some further detail, the trust met the 92% target and was above the England average in some of its leading specialities (taking patient numbers of above 200). These were urology, ear, nose and throat, ophthalmology, rheumatology and gynaecology. The exceptions, which were not significantly below the target, were trauma and orthopaedics (87.8%), gastroenterology (90%), cardiology (86.9%) and ‘other’ (90.1%).

The highest percentage of delayed patients (patient numbers above 200) was in cardiology, where 51 patients were waiting over 18 weeks (13.1%). This was higher than the England average of 10.1% delayed patients. In the smaller specialities for the trust, there were very few patients waiting over 18 weeks in general medicine and geriatric medicine. Of the 152 thoracic medicine patients, 14 were delayed more than 18 weeks, although the specialty had almost the 92% target at 90.8% in January 2019. Of the 74 general surgery patients, 11 were delayed by more than 18 weeks, and just 85.1% had been seen within the standard. This was the lowest result for the trust, although just about the England average for January 2019 (84.4%)

Cancer performance

The trust had been failing to meet most of the cancer performance standards. In the first three quarters of the current year (April to December 2018 with October to December provisional data) and into January 2019 (the most recent data), the trust had a mixed picture against the key national standards for seeing and treating cancer patients. This was within a picture where the national waiting times for cancer treatment were the worst on record. Taking January 2019 (still provisional) for detail, in a mostly deteriorating picture the trust met none of the five of the key standards listed below. There were significant failures to meet the standard in the 31-day wait for surgery and 62-day wait for first treatment. In the 62-day wait, less than half the patients were seen in 62 days. However, it should be noted that the numbers of patients were low, so there can be large percentage variations with small data sets.

<table>
<thead>
<tr>
<th>Standard (all data currently published as ‘provisional’)</th>
<th>Apr-Jun 18 (England avg.)</th>
<th>Jul-Sep 18 (England avg.)</th>
<th>Oct-Dec 18 (England avg.)</th>
<th>January 2019 (England avg.)</th>
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[Table continues with data for each standard]
Looking at the two-week wait standard in more detail: the trust had met the standard in Q1 (Apr-Jun 18) before the position deteriorated in Q2, Q3 and January 2019, although close to 90% (standard 93%). The trust also dropped below the England average in those months. For exhibited (non-cancer) breast symptoms where cancer was not initially suspected, the picture was the same, although the trust was close to target having recovered by January 2019.

In the detail behind the two-week waiting time data for Q1, Q2 and Q3, the good performers among the larger patient groups (>100 patients) were urological malignancies and upper gastrointestinal cancer (above the target to be seen within two weeks). Performance for patients with suspected gynaecological cancer improved across these nine months from 81% in Q1 to 97% being seen within two weeks by Q3. Performance in lower gastrointestinal cancer improved by Q3 to 96% from 78% in Q2.

Breast cancer performance had a mixed picture. In Q1, the trust had seen 96% of patients in two weeks, but this had dropped to 83% by Q3. The position had recovered by January 2019 to 98% and just two patients not being seen in two weeks.

Those specialties not meeting the target were for lower numbers of patients. It included suspected lung cancer, which had deteriorated to just 65% of patients being seen in two weeks by Q3. This had deteriorated from Q1 when the trust was seeing 90% of patients in two weeks. This figure had become far more significant by January 2019 when only 20% of the 15 patients were seen in two weeks.

Diagnostics

**There was a good performance for diagnostic imaging performance.** Working to the national standard for diagnostics, the trust had performed exceptionally well and met the standard in all but one month (April to January 2019). This standard stated that no more than 1% of all patients should wait more than six weeks for a diagnostic test. The only month where this was exceeded was August 2018 with 1.5%. Nevertheless, in September to December 2018, the trust saw all patients in six weeks and 0.5% were waiting in January 2019.

Infection prevention and control

**Results around infection prevention and control were varied.** The trust board were given detail on hospital-apportioned infections and avoidable harm through the monthly performance report (which covered clostridium difficile and MRSA cases). The trust also provided us with the annual infection prevention and control report 2017/18. This was presented to the trust board.
quality and safety committee in May 2018 and the trust board in July 2018. The report was presented by the lead nurse for infection prevention and control and the director or nursing for infection prevention and control who was the trust’s director of infection prevention and control. The trust had achieved some good results in the 12 months from February 2018 to January 2019 (the most recent data at the time of writing), and the highlights were:

- Nine reported cases of clostridium difficile. There had been none reported in the last quarter of the 12 months, which covered much of the winter period. This was against a standard of reporting no more than 17 cases in one year.
- One reported case of MRSA bacteraemia. This was against a standard of reporting no cases (zero).
- Eight cases of methicillin-sensitive staphylococcus aureus (MSSA). This was against a standard of reporting no more than 5 cases in one year.
- There were some areas of antibiotic stewardship where performance had deteriorated or required improvement.
- The trust was almost meeting the target for compliance with antimicrobial data on medicine charts. The target was for more than 90% to be accurate and results were around 89% each month. However, there was no data available in August to October 2018.
- There were 21 incidences of E coli, although no target was given. This number is generally in line with those of similar organisations.

During the well led inspection we met with the trust team with responsibility for infection prevention and control. We found a motivated group with effective processes for gaining assurances around infection prevention and control at the trust. Oversight was a positive process, and the team were proactive in managing the challenges presented by infection prevention and control.

Patient harms, readmissions and assessments

There had been some incidents of avoidable harm coming to patients at the hospital. The board performance report recorded the number of hospital-acquired pressure ulcers, and for the more serious categories, three and four, reported seven category three and one category four in the eleven months from April 2018 to February 2019. The trust had been set a standard to reduce category three pressure ulcers by 50% and category four by 100%. However, it did not report whether it was achieving or progressing towards this standard.

There had been 13 falls with moderate of severe harm coming to patients in the 12 months from April 2018 to February 2019. The trust standard was to reduce the number of serious falls by 25%, but it did not record whether it was achieving or progressing towards this standard. In another measure of safety around falls, the trust had a standard to be below 5.63 falls per 1000 bed days. In the 11 months from April 2018 to February 2019, the trust had achieved this in eight months and the trajectory was improving.

Patient readmission rates were not meeting the standard to be below 6% of patients. In the 11 months from April 2018 to February 2019, the trust had achieved an average of 6.6% and been below the 6% target in just three months.

One standard being met most of the time was for at least 90% of patients with a fractured neck of femur to be seen and assessed by an orthogeriatrician. In the 11 months from April 2018 to
February 2019, the trust had achieved an average of 90% and been below the 90% target in just two months. It had achieved 100% in three of the months.

Food standards

The patient-led assessment of the care environment (PLACE) score for food had slightly deteriorated in 2018 from 94% in 2017 to 91.7% in 2018. Ward food scores had also deteriorated from 99% in 2017 to 92.9% in 2018.

There were ongoing concerns about the sustainability of the financial situation at the trust. The trust had been identified as clinically and financially unsustainable in its current form by a number of external reviews. It had reported deficits in recent years and this was expected to occur again during the current financial year. Financial risk and the sustainability of the organisation featured as a significant risk on the board assurance framework and board members were able to clearly articulate the key drivers.

The finance report to the Board identified risks to the position but this was included within separate sections of the report. There was an established performance review process with the divisional teams with the chief operating officer reviewing the current position and future delivery expectations in a weekly meeting.

Assessment and management of risks relating to pharmacy provision was a mixed picture. The medicines safety officer role was held by a senior pharmacist and alerts were received and actioned as appropriate with a summary of actions fed back to the medicines committee. Medicines safety actions were embedded in the medicines optimisation workplan and were supported by an audit programme.

The medical director was the controlled drug accountable officer (CDAO), but they did not attend the local controlled drug local intelligence network meetings. The minutes of these meetings were received by the CDAO but were not shared with the pharmacy department or chief pharmacist.

There were 12 moderate risks on the pharmacy risk register covering all aspects of the service. Although measures were in place to provide assurance that risk was managed, these were often reactive, and the risk rating had only reduced for three risks (from high to moderate) upon review.

Medicines and pharmacy risk had been added to the corporate risk register in July 2017. This identified that there was a risk that the trust would be unable to comply with the following medicines related external objectives and targets:

- Comply with CQC must and should do medicines related recommendations from previous report.
- Comply with DH standards for provision of medicines via homecare.
- Comply with NHSI targets within the pharmacy and medicines section of the Model Hospital Dashboard.
- Comply with targets agreed with commissioners for medicines reconciliation.

The pharmacy service had no way of assessing which patients were high risk. There was not enough of a ward based service to monitor prescribing of high risk medicines, for example high dose opiates, antibiotics, or insulin. Prescription charts were reviewed by pharmacy staff based on the need for stock rather than clinical need.

There were arrangements for identifying, recording and managing risks, issues and
mitigating actions although these were not always effectively managed. We reviewed the trust risk register which contained a wide range of risks, both clinical and non-clinical. Some risks had necessarily been on the register for a sustained period of time, staffing, for example. Others, graded as moderate risks had been on the register for three years – for example the risk of a lack of training for advanced life support, and had not been mitigated to a manageable level in that time. Likewise, the failure to meet national cancer targets had been on the register as a high risk for two years with an apparent lack of progress in improving this overall picture.

Other risks which we found, were not on the risk register at the time of our inspection but clearly jeopardised the smooth running of the organisation. For example, the lack of infrastructure to support clinical lead roles, and the lack of capacity of the executive team to meet the wide-ranging demands of their roles.

We were not assured therefore that the risk register was being used to its full benefit, and that all risks that should be on it were captured.

The Board Assurance Framework was reviewed by the board and included the key risks that would be expected for this organisation regarding finance, workforce and quality. The chair indicated that work had been done recently to refresh risk management processes but the exact nature of the changes was not confirmed.

In pharmacy, there was a comprehensive and clearly written risk register which captured the risks we saw during our inspection. However, the key issue of a depleted pharmacy workforce was compounding the risks and affecting the trusts ability to mitigate them. For example, the lack of a clinical ward based service, meant that patients did not have their medicines checked on admission, during their stay or at discharge. Patients taking high risk medicines could not be identified and prescription charts were only reviewed based on the need for further stock. Discharge medicines were dispensed from the prescription chart before the discharge summary was produced. The medicines section of the discharge summary was transcribed without any pharmacy input. This led to errors in both the discharge summary and the medicines supplied at discharge. Therefore, while the risk register captured the risks well, it did not appear to be being used to improve safety of services in pharmacy.

The risks of the environment and estate were well understood and managed. We saw strong and competent leadership of the estates service. We met with the estates lead who was relatively new into post, although clearly had a comprehensive understanding of the risks and challenges of the environment and estate of the trust. There was a very limited budget for maintenance of the estate, and, not unusually a backlog of work needing completion. However, none of the outstanding works provided a significant risk to patients, staff or visitors. There was a need for an overhaul of the mortuary which had not been refurbished since the hospital’s opening in the late 1980’s. This work was planned for quarter three of the 2019/20 financial year.

The capital plan for the trust, was driven by the capital planning group which devised a five-year plan. The estates lead planned to ask for this plan to be redeveloped by the group to reflect current challenges at the trust.

The estates lead described a programme of the installation of doors in ward areas which aimed and succeeded in minimising the number of wards and beds closed due to norovirus and other infectious diseases.

Staff could contact the estates team through a helpdesk. We heard that this system worked well and issues were responded to quickly.
The trust was around the national average when asking for the patient’s view of the environment. Three of the four indicators had improved. The patient-led assessment of the care environment (PLACE) scores for those areas related to the environment had mostly improved for 2018 and were mostly above the national average:

<table>
<thead>
<tr>
<th>PLACE Subject</th>
<th>Trust score 2018</th>
<th>National average 2018</th>
<th>Trust score 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleanliness</td>
<td>98.6%</td>
<td>98.5%</td>
<td>99.2%</td>
</tr>
<tr>
<td>Condition, appearance and maintenance</td>
<td>93.5%</td>
<td>94.3%</td>
<td>91.1%</td>
</tr>
<tr>
<td>Environment for people living with dementia</td>
<td>80.5%</td>
<td>78.9%</td>
<td>76.6%</td>
</tr>
<tr>
<td>Environment for people living with a disability</td>
<td>85.6%</td>
<td>84.2%</td>
<td>82.3%</td>
</tr>
</tbody>
</table>

**Accessible Information Standards (AIS)**

The trust did not have an accessible information standards policy, and had yet to audit its service against compliance with the requirements of the AIS. The AIS were published by NHS England in 2015. It required NHS trusts to have a consistent and specific approach to how it identified, recorded, flagged, shared and met the information and support needs of patients, service users, carers, and parents with a disability, impairment or sensory loss. From August 2016, all organisations providing NHS care were required to follow the standard in full. The trust did not have a separated AIS policy, with reference to it being made in the accessible information policy of the trust. Each organisation was required to do five things within the standard to be compliant. The trust had not undertaken this work at the time of our inspection.

**Assurance was provided to the trust through a trust board committee covering audit and assurance.** The trust’s audit committee was a sub-committee of the board. It received reports from both internal and external audit work. The committee included, amongst others, non-executive directors, (one of whom was the chair of the committee), and was also attended by the director of finance and trust secretary. The trust’s external auditors were also invited to be in attendance. We reviewed the annual report of the committee submitted to board in May 2018. The report contained clear areas of responsibility of the committee, with clear aims and objectives around the work of the committee. Quarterly reports to board written by the committee were presented at private board.

**The trust recognised and understood its risks in terms of business continuity and planned for major incidents.** NHS England required trusts to have suitable and up to date plans when faced with disruptions, but recognised these needed to be proportionate. Disruptions could be for example, from severe weather, failure of systems or power, or an outbreak of an infectious disease. The trust had a business continuity plan, but this had not been reviewed since 2017. This carried the risk that the plan contained out of date information that could be referred to in error in the event of an emergency. The plan set out the roles and responsibilities of various staff in times of a major incident or loss of business continuity.

The director of operations held the role of accountable emergency officer with responsibility for planning in the event of an emergency. Details of this role were described clearly in the policy together with details of other roles who would report into the accountable emergency officer if the need arose. The business continuity plan also contained information on actions in the case of a major incident.

**Information management**
There was an understanding of the importance of timely, accurate, detailed and relevant information although the reality of this presented a mixed picture. The information technology infrastructure at the trust was poor, with associated challenges commonplace across the organisation. The trust had recognised the need for improvement and submitted an information technology bid for £10m via the CCG Sustainability and Transformation Partnership (STP) to the Department of Health. The bid received the support of the STP to replace the trust’s IT infrastructure and associated systems. The bid, if obtained would fully fund the replacement of the trust’s legacy IT infrastructure, which was seen to be key to improving data quality and responsiveness in the trust. For example, the investment in an electronic patient record would bring significant benefit to timeliness, response and decision support. We heard both during our core services and well led inspections of the difficulties faced by the lack of effective information technology, but this did not feature on the trust risk register.

The trust felt that, overall, data quality was fair. The trust’s health informatics committee (HIC) was responsible for improving data quality and were prioritising an action plan to take forward data quality improvements within the limited resources available. For example, data held on the patient administration system (PAS) was not currently captured in real-time and often entered retrospectively. To ensure data was accurate, the trust employed data reviewers/correctors in support of data submission. The trust had an agreed data quality improvement plan (DQIP) agreed with the CCG.

The current integrated performance report was developed in engagement with the NEDs. A review of this confirmed that it focused on historic performance rather than using projections as a way of looking forward and informing the board. Discussions during our inspection confirmed that board members considered hard metrics and softer indicators (such as staff survey results) to gain a view of overall performance. There was some evidence of triangulation between financial, operational and quality data within the performance report, but this was largely limited to the impact on finance of activity.

Cost improvement programme delivery was a particularly challenging area for the trust. However, the information provided on CIPs to the trust board was limited in detail to allow in-depth understanding of delivery and risks. There wasn’t detail on what was being done to mitigate high risk schemes. A more detailed review took place at the finance and performance committee; however, concerns were identified during our inspection with respect to how individuals were being held to account for delivery and the robustness of plans. Public board minutes didn’t reflect a robust discussion regarding these during the meeting or as part of the board committee exception reports.

In pharmacy there was a lack of a programme of internal audit to provide information to the trust about pharmacy related outcomes. The only audit was a quarterly controlled drug audit. A safe and secure handling of medicines audit was undertaken at ward level, but the actions and outcomes were not shared with pharmacy. This meant that leadership in pharmacy could not monitor medicines optimisation processes or medicines safety.

However, the chief pharmacist reported controlled drug (CD) incidents to the CD local intelligence network and submitted quarterly occurrence reports.

Information Governance Toolkit assessment

The trust met all the requirements to satisfy the Department of Health NHS Information Governance Toolkit assessment in 2017/18 (most recent), meeting all 45 measures, although performance was slightly below the previous year. The trust had completed the assessment to describe how it saw its management and security of information. The trust self-
assessed performance on measures of assurance, which extended to confidentiality and data protection, the quality of information, the secondary uses of information, and a measure of overall performance. In the 2017/18 declaration, the trust assessed its overall performance as ‘satisfactory’ due to meeting all the required level two assessments, and 12 achieving the highest level three status.

Otherwise, the overall score for 2017/18 was 71%, which was a 2% decline over the previous year’s score.

General Data Protection Regulation

The trust had managed and implemented the new rules and guidance around the General Data Protection Regulation (GDPR) 2018, and had published on its website as to how it was using and protecting information. The new regulation required the trust to ensure it protected patients’ and staff data under specific legal obligations. The trust had published on its website its statement of what information it held about both patients and its staff and why it needed this information. This information was contained in the trust’s privacy notice, which was signposted on the website in the section around information governance.

The trust understood the need for patient records to be held securely and unauthorised people prevented from access, although this did not always happen. Our inspection of core services within the trust raised some concerns about the security of records, within the Child and Adolescent Mental Health Service (CAMHS). However, we did not find the security of patient records to be a cause for concern in the other core services we inspected. In these areas we saw that staff consistently locked records away in suitable cabinets which were stored securely and we did not see any behaviours that suggested security of confidential information was anything other than a priority.

There were effective arrangements for ensuring that data or notifications were submitted to external bodies as required. Those external bodies we asked reported no concerns with the timeliness or quality of data that was provided to them. This included regular reporting to the various areas of the NHS for which the trust was mandated to report. However, the trust was late in providing some data to external audits, for example the Royal College of Emergency Medicine (RCEM) audits.

Engagement

The trust engaged in a variety of ways with the public and local organisations to plan, manage and deliver services. The trust was part of the NHS friends and family test, but also undertook more tailored surveys for its services. This included collecting feedback via exit cards from inpatient areas, a local inpatient survey collected using the “Perfect ward” system, a website feedback form and through the patient advice and liaison service (PALS). Feedback from these sources had led to a number of localised changes – for example around visiting times, and temperature control in certain areas of the hospital.

The trust had a patient experience and engagement strategy, that was dated from 2016 – 2018. We did not see a version of this document to supersede this strategy when we inspected in 2019. The strategy described how engagement was being used to shape the development of the trust and was comprehensive in its description of successes and challenges. There was clear engagement in the strategy from the patient council who were felt to be a well utilised part of the engagement process at the trust. Patient council representatives were also invited to sit in on the board meetings at the trust and contribute. We saw this opportunity actively utilised during the board meetings we attended prior to the inspection.
As part of the Healthy Weston proposal, the trust was engaged in public consultation around how this piece of work would affect the local population. This was in progress at the time of our inspection and was being led by the clinical commissioning group.

The pharmacy service engaged with system-wide support in its service delivery. The chief pharmacist participated in the south west chief pharmacist network and relied on colleagues for peer support. The local clinical commissioning group area had a medicines optimisation work programme with key themes identified.

**The trust had services to meet the spiritual or religious needs of patients, carers and staff.** The trust had a chaplain and a team of volunteers to support the chaplaincy service. The service provided a 24-hour on call emergency service in addition to being available Monday to Friday, 9am to 5pm. The chaplaincy was available for people of any faith, or those of none and the team knew and could contact local faith leaders in the community for guidance and advice. The chaplain’s team visited wards, and also met people in the hospital chapel which was designed both for people of faith, and those of no faith.

**The trust supported a team of volunteers.** We met with a group of volunteers together with representatives from the patient council. Volunteers provided a range of services both patient facing and otherwise and were managed by a voluntary services manager. Volunteers were used in a variety of ways – for example to visit patients with no visitors, to support at mealtimes, as support to the chaplaincy, and in an administrative capacity.

Those we met said they felt valued and appreciated wherever they worked at an operational level. They felt the environment at the hospital site was positive and they were proud of the contribution they made. However, they did not feel engaged or valued by the leadership team at the trust and had had very little involvement with them. Fifty percent of the volunteers we spoke with said they never saw the executive team during the course of their work at the trust. However, the volunteer lead sat on the patient experience review group and had an agenda item to provide direct feedback via a report to the director of nursing who chaired this committee. The director of nursing attended both the patient council meeting and the League of Friends committee meetings to gain feedback. Volunteers received induction but also an adequate amount of opportunity to develop competence and confidence in the role. Recruitment processes were thorough with references sought, and checks made against the disclosure and barring service register where necessary.

Information was available on the trust’s website about the work of the volunteers as well as information on how to become a volunteer at the trust.

**Engagement with staff had variable levels of success in this organisation.** The 2018 NHS staff survey showed no particular improvement in questions associated with staff engagement. Some of these questions, many significantly below (worse than) the national average for acute trusts, were low results, particularly those around question nine (see below). Question nine responses showed only around a quarter of staff felt there was good involvement with and feedback to staff.

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score 2018</th>
<th>National Average</th>
<th>Trust Score 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4b: I am able to make suggestions to improve the work of my team/department</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
</tr>
</tbody>
</table>
Q8d: My immediate manager asks for my opinion before making decisions that affect my work | 48% | 54% | 45%
Q9b: Communication between senior management and staff is effective | 26% | 41% | 25%
Q9c: Senior managers here try to involve staff in important decisions | 24% | 34% | 24%
Q9d: Senior managers act on staff feedback | 23% | 32% | 20%

Note: for the above questions, the percentage featured is that of ‘Yes’ responses.

Additionally, we heard both in the core services inspection and with those operational staff we met on the well led inspection, that feedback from the leadership team was often poor. Whilst endeavouring to encourage staff to raise issues and make suggestions, closing of that feedback loop was often seen to be ineffective with poor, if any, responses made.

**Engagement with unions was poor.** We were not assured of effective engagement with recognised unions at the trust. We met with representatives during our inspection who felt disengaged with the trust – particularly in relation to performance management processes but also in what they felt was a complete lack of investment in their role. The most recent chair had stepped down due to the ongoing and sustained impact of their substantive role and well as feeling disenchanted with the way in which unions were treated at the trust. Union representatives had no protected time for the role, and as such carried out this work mainly in their own time. This also affected their ability to be available to their members. We were not assured therefore, that the infrastructure required surrounding union presence was robust enough to withstand the demand on capacity of the planned changes surrounding Healthy Weston and the planned joining with a local trust.

**The trust recognised the importance of engagement with stakeholders and partners.** The trust had worked hard to engage and work with stakeholders and partners. The trust was required to take part in enhanced oversight and engagement processes requiring additional reporting. Our observations of the trust, both in meetings and through our continual engagement and monitoring, provided assurance that they were engaging well with the system and the stakeholders within it.

The trust was working closely with the clinical commissioning group on the Healthy Weston project, and were providing collaborative leadership of this piece of work.

The trust had also developed increasingly closer partnerships with the local trust with which it was planned to join in 2020. This included forging working relationships at a clinical level, while inviting peer support into the trust to improve services.

Additionally, the trust was working closely with another local trust bringing together services to improve their provision and effectiveness to the local populations.

**Learning, continuous improvement and innovation**

**Incidents were not always used to learn and improve.** The trust and its staff understood the importance of learning from incidents and near misses. We were assured from talking with staff and from the staff survey that most staff were diligent with reporting incidents. Those we met
recognised when something should be reported, including it being a near-miss although we did find evidence in some of the core services we inspected that this did not always happen. In the 2018 NHS staff survey, 95% of staff said they were reporting errors, near misses or incidents witnessed in the last month that could have hurt staff or patients. We reviewed the reports from five serious incidents. We found that in those reports there was a clear focus on learning from what had happened rather than finding blame. However, our experiences during core services did not provide assurance that learning was disseminated effectively with very few people able to articulate an example of any changes to practice as a result of incidents.

**The trust had implemented the required systems and publications to show how it aimed to learn from deaths.** The trust had met its requirement to publish its policy around learning from death. The 2017 NHS National Quality Board guidance required the trust to publish its current mortality review policy on its website. This was in date and approved through clinical governance. It included recognition that, as required, certain deaths, such as those of a child, a patient with mental ill health, or patient with a learning disability, were to be investigated through other routes and with predefined tools.

As required, the trust openly reported each quarter through board reports but was not placing these on the dedicated webpage on learning from deaths. The overall responsibility for mortality reviews sat with the medical director.

The review of mortality was discussed at the monthly meeting of the clinical effectiveness group. Learning was disseminated through directorate governance meetings, a clinical effectiveness showcase event, as well as the “We Smile” quality and safety publication. Teams used the Royal College of Physicians “structured judgement tool” to review deaths. The trust aimed to subject 50% of all deaths to a structured judgment review (independent of the team looking after the patient at the time of death). This included deaths where concerns had been raised by staff or patients about care, deaths that had occurred contemporaneously with a serious incident or never event, as well as a random sample of “expected” deaths. However, we heard that since the departure of the chief registrar for reviews of deaths in late 2018, the percentage of deaths at the trust subject to a structured review had fallen below the 50% target, with 30% being achieved in December 2018, and remaining around that number in the months leading to our inspection.

**The trust involved patients and families in reviews of death or serious incidents.** Our conversations with the mortality lead, described a process for working with families following deaths. All families were written to in the event of a death that was deemed duty of candour applied. The families were invited to frame the terms of reference of any investigations, and where necessary were visited at home. Families were also supported through the process of coroners’ hearings where needed or debriefing if required.

**There were systems to improve the service and performance which aimed to provide continuous learning and quality improvement projects.** The trust ran a number of quality improvement (QI) projects including, as required by their training programme, the junior doctors’ QI projects. Alongside this were QI projects running throughout the trust of various scale and involvement from staff. Often these projects had originated from, for example, audit work, or trust priorities within its strategy. Priorities for QI projects at the time of our inspection included prevention of falls, support of frail patients, and reducing harms from medicines. We heard that the lack of an effective information technology system to support QI could present a challenge due to the increased resources needed to facilitate the projects.

The trust had introduced a transformation team to assist and support in the delivery of key projects including cost improvement. There had been the development of the quality
improvement programme for the next 12 months which provided oversight of several key quality projects including the quality account.

There was a lack of information available that related to development through research. There was little information available regarding the role of research at the trust. The policy available on the trust website, was last reviewed in 2013, although there were contact details for the research and development team.

The trust could report on a number of accreditations it had achieved. NHS trusts can participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which of the trust’s services have been awarded an accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>Endoscopy Unit, 21 February 2018</td>
</tr>
<tr>
<td>Imaging Services Accreditation Scheme (ISAS)</td>
<td>Imaging Department, achieved 2015</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189</td>
<td>All Pathology UKAS accreditation achieved 2017</td>
</tr>
<tr>
<td>Quality Network for Community Child and Adolescent Mental Health Services (QNCC)</td>
<td>QNCC- achieved for CAMHS and Eating disorders in 2016</td>
</tr>
</tbody>
</table>

**Acute services**

**Urgent and emergency care**

Facts and data about this service

Details of emergency departments and other urgent and emergency care services

Urgent and emergency care services are provided in the hospital’s emergency department (ED) seven days a week, 365 days a year. The department is open from 8am until 10pm. There is a co-located ambulatory care unit; this is reported on under Medical care.

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

Activity and patient throughput

Total number of urgent and emergency care attendances at Weston Area Health NHS Trust compared to all acute trusts in England, October 2017 to September 2018
From October 2017 to September 2018 there were 47,609 attendances at the trust’s urgent and emergency care services as indicated in the chart above.

(Source: Hospital Episode Statistics)

Urgent and emergency care attendances resulting in an admission

The percentage of ED attendances at this trust that resulted in an admission increased in 2017/18 compared to 2016/17. In both years, the proportion was higher than the England average.

(Source: NHS England)

Urgent and emergency care attendances by discharge method, from October 2017 to September 2018
* Discharged includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

**Is the service safe?**

**Mandatory training**

The service provided mandatory training in key skills to all staff; however, they did not make sure everyone completed it.

Staff were not up to date with mandatory training and completion rates for medical staff were particularly poor. This meant we could not be assured they were familiar with safety systems and processes.

Nursing staff told us they felt well supported with training, which was both classroom-based and face-to-face. Staff were given protected time to complete mandatory training or paid if they completed it in their own time. Staff and managers were able to monitor training compliance and managers sent reminders to staff when they were due for refresher training. Staff could book training places on line.

The trust set a target of 90% for completion of mandatory training.

A breakdown of compliance for mandatory training courses as of February 2019 for registered nursing staff in the emergency department is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Completion rate</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>95.2%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>95.2%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>95.2%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>77.8%</td>
<td>No</td>
</tr>
</tbody>
</table>
Data provided during our inspection showed:

- 66.7% of health care assistants had completed basic life support training
- 53% of registered nurses had completed advanced life support training
- 37% of registered nurses had completed advanced paediatric life support training
- 87.9% of registered nurses had completed paediatric immediate life support training

A breakdown of compliance for mandatory training courses as of February 2019 for medical staff is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Completion rate</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>79%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>83%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>79%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>50%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>56.6%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source DR118 Statutory training compliance ED and medicine)

Data provided by the trust during our inspection showed:

- 85.7% (6/7) of consultants had completed advanced life support training
- 85.7% (6/7) of consultants had completed advanced paediatric life support training
- 27.2% (3/11) of middle grade doctors had completed advanced life support training
- 36.4% (4/11) of middle grade doctors had completed advanced paediatric life support training

**Safeguarding**

**Systems and processes to safeguard adults and children from abuse were not robust; staff had not received adequate training and did not always follow processes.**

Staff could describe signs of abuse and the actions they would take to safeguard adults and children. Staff were prompted to consider safeguarding when they performed initial assessment (triage) and they were required to record whether there were any safeguarding concerns. On the back of the patients’ record there was a list of signs and risky presentations for staff to be aware of.

There were trust-wide safeguarding leads and staff knew who these were and how to contact them but lead clinicians for safeguarding had not been identified in the emergency department. *Facing the Future: Standards for Children in Emergency Care Settings* (2018) produced by the Royal College of Paediatrics and Child Health recommends that all emergency departments nominate a lead consultant and a lead nurse responsible for safeguarding. Training in safeguarding was mandatory (the trust’s target attendance rate was 90%); however, not all staff
had completed appropriate levels of safeguarding training. Of concern, was the poor compliance rate for senior medical staff.

**Safeguarding adults**

A breakdown of compliance for adult safeguarding training courses as of February 2019 for staff in the emergency department is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Safeguarding Adults level 1</th>
<th>Safeguarding Adults level 2</th>
<th>Safeguarding Adults level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior medical staff</td>
<td>72%</td>
<td>61%</td>
<td>0%</td>
</tr>
<tr>
<td>Junior medical staff</td>
<td>100%</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Nursing staff band 5 and below</td>
<td>97%</td>
<td>76%</td>
<td>0%</td>
</tr>
<tr>
<td>Nursing staff band 6 and above</td>
<td>95%</td>
<td>100%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Intercollegiate Guidance for Adult Safeguarding, *Adult Safeguarding: Roles and Competencies for Healthcare Staff* (2018) states that registered health care staff who engage in assessing, planning, intervening and evaluating the needs of adults where there are safeguarding concerns should complete level 3 training. The trust told us they were working on a training plan to deliver this.

Staff knew how to support patients where there was suspected domestic abuse. There was a trust-wide complex needs sister, who had taken on the role of domestic violence champion. They visited ED daily and ensured victims were signposted to external agencies. There was a domestic abuse question on the paper patient record to prompt staff.

Staff told us they had not received training in female genital mutilation or child exploitation and were unaware if there was a trust policy or guidelines. However, they told us they would report concerns to the consultant paediatrician employed by the trust or the trust-wide safeguarding lead.

Most staff had received training in preventing radicalism.

*(Source: DR8 Safeguarding reports)*

**Safeguarding children**

*Safeguarding Children’s Standards* produced by the Royal College of Emergency Medicine requires that all senior emergency department doctors should have level 3 training in safeguarding children. All nursing staff and all junior medical staff should have safeguarding children training at level 2. These standards were not met, as shown in the table below, which shows a breakdown of child safeguarding training as of February 2019:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Safeguarding Children level 2</th>
<th>Safeguarding Children level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior medical staff</td>
<td>N/A</td>
<td>66.7%</td>
</tr>
<tr>
<td>Junior medical staff</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Nursing staff band 5 and below | 84% | 16%
Nursing staff band 6 and above | N/A | 90%

(Source - DR8 Safeguarding reports)

ED staff could access a senior paediatric and senior emergency medicine opinion 24 hours a day for child welfare issues. *Facing the Future: Standards for Children in Emergency Care Settings* (2018) produced by the Royal College of Paediatrics and Child Health recommends that staff in emergency care settings have access to safeguarding advice 24 hours a day from a paediatrician with safeguarding expertise. From Monday to Friday, 8.30 am to 5 pm, there was a paediatrician on the children’s unit, and on call from 5 pm to 10 pm, who could be contacted for advice. Out of hours advice was provided by a dedicated shared rota provided by local healthcare organisations. There were systems in place to identify children at risk of abuse. Reception staff were able to review the child protection register. If a child attending the emergency department was found to be on the register, their record was stamped to alert clinicians of this risk. Staff were alerted to a child’s previous attendance history, which was printed on the patient’s record.

There were systems in place to ensure child protection concerns were shared with other health professionals and agencies. Staff were required to complete primary care notifications (PCNs). There was a ‘safety net’ process in place, whereby children’s nurses from the Seashore children’s unit reviewed the records of all children and young people who attended the emergency department to review whether safeguarding issues had been adequately considered and assessed and whether appropriate notification had taken place. It was noted at the ED governance meeting held in January 2019 that review of children’s records in November and December 2018 had highlighted 28 and 29 PCNs respectively had not been completed by ED staff and these had been completed retrospectively by Seashore staff. This suggested to us there was a training need. It was recorded in the minutes that the front door matron and director of nursing were “focussing” on this. There were fortnightly safeguarding supervision sessions provided in the emergency department to improve staff awareness and confidence.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. The emergency department appeared clean and tidy. Staff used control measures to prevent the spread of infection.

Premises and equipment were clean. Records were kept showing that cleaning tasks were undertaken regularly. Cleaning equipment and materials were appropriately stored in the domestic cupboard. We saw staff cleaning trolleys between patients. Equipment stored in the clinic room was clean and ready for use. Staff labelled equipment with ‘I am clean stickers’ to show that it had been cleaned and was ready for use. Cubicle curtains were disposable and changed regularly. The curtains we checked were clean and were marked to show when they were due for replacement.

There were arrangements for the segregation and safe disposal of waste and staff complied with these. Clinical waste was disposed of separately and then stored in a designated secure area. Sharps bins were stored safely above floor level and were sealed and appropriately labelled.

The service audited the cleanliness of the environment monthly. Compliance was 100% in November 2018 and 99% in December 2018 and January 2019.

Staff observed standard hand hygiene procedures and complied with the uniform policy. All staff were ‘bare below the elbow’. There were appropriately-sited hand washing basins in all areas.
and hand soap was dispensed from single-use cartridges. We saw staff wash their hands in between episodes of patient care. Notices reminded patients and visitors to clean their hands at the entrance to the department and there was hand sanitising gel available in all areas. The was a notice to staff, informing them that they may be challenged if they did not observe good hand hygiene practice.

The service audited hand hygiene monthly. Compliance with hand hygiene standards was 90% in November 2018, rising to 100% in December and January 2019.

There was a documented procedure to ensure that infectious patients were isolated in the emergency department to prevent the spread of infection. There were two side rooms where infectious patients could be cared for. Patients were screened for MRSA (an infection resistant to treatment). Audits showed 100% compliance in November 2018 and 99% compliance in December 2018 and January 2019. Staff were alerted, using a yellow warning indicator on their records, if they had previously been infected with MRSA during a hospital admission.

Staff had completed training in infection prevention and control (although attendance for medical staff was below the trust target) and there was an infection control link nurse in the emergency department, who was a source of advice. The contact details for the hospital’s infection prevention and control team were also available to staff.

**Environment and equipment**

**The service had mostly suitable premises and equipment and looked after them well.**

The emergency department was well laid out and there was adequate space for staff to work safely. There was easy access from the ambulance entrance to the resuscitation and major treatment areas. There was easy access to X-ray and scanning facilities.

The emergency department was mostly well maintained. There had been a reconfiguration and refurbishment of facilities in 2018 and the décor had been refreshed; however, flooring in some areas was in need of repair. Some areas were covered with tape as a temporary measure but in places the floor covering had lifted, resulting in a trip hazard. This was on the risk register. A staff member tripped on this uneven flooring and reported an incident in November 2018. No action was recorded following this incident. Following our inspection, the trust told us it had replaced flooring in April 2019, in response to this incident.

The emergency department waiting room could not be fully viewed by the reception staff, although there was a mirror to increase visibility of the whole area.

There was a separate waiting area for children, as recommended by the Royal College of Paediatrics and Child Health in *Standards for Children and Young People in Emergency Care Settings* (2012). There was a notice displayed in the children’s waiting area to instruct parents not to leave children unattended in this area. This, to some extent, mitigated against the risk that children could not be observed by staff while they waited in this area.

Although the provision of a separate waiting area for children allowed audio and visible separation from the main waiting area and access could be controlled by the receptionist; this was not maintained. We noted that the door to this room was frequently propped open, even when occupied. During our second visit this was the case for the five hours we were in the department. At one time we saw a young child wander to the door and interact with an adult in the main waiting room.

There was a dedicated room for the assessment of patients who had a mental illness. This had some safety features, as recommended by the Psychiatric Liaison Accreditation Network (PLAN),
such as panic alarms and two doors, one of which was a swing door. However, some furniture and fittings could be used as a weapon, including computer terminals, office chairs, a small filing cabinet and an unsecured picture on the wall. As such, it did not fully meet PLAN standards. An incident was reported in November 2018 where two staff had been trapped in the assessment room by an aggressive patient. They were unable to reach the panic alarm. When they did manage to raise the alarm, they were advised by security they would not be able to respond for 20 minutes. The actions arising from the incident were to improve the alarm system and discuss with security staff prioritising calls to assist with incidents involving violent and aggressive patients. There was no evidence provided to us to show that these actions had been progressed. At the time of our inspection the alarm system had not been improved.

The emergency department was well equipped; equipment, including emergency equipment, was readily accessible and well maintained. Records were kept and equipment was labelled to show that it was regularly checked, it was clean and in good working order. This was an improvement since the last inspection.

Patients had access to call bells so they could summon help from staff.

**Assessing and responding to patient risk**

**Staff did not always assess and respond to patient risk and monitor their safety.**

**Patients were not always assessed promptly on arrival in the emergency department, to ensure that those with serious or immediately life-threatening illness or injury were identified and prioritised.**

There were frequent ambulance handover delays and patients were not always assessed within the timescale recommended by the Royal College of Emergency Medicine.

Although we saw prompt handover of patients by ambulance staff and prompt initial assessment of both ambulance-borne and self-presenting patients during our inspection, data showed that this was variable and some patients continued to experience delays.

**Ambulance handover and initial assessment**

Patients arriving by ambulance were not always handed over promptly to emergency department staff. During our inspection we saw efficient and prompt handover of patients; however, data showed that this was not consistent.

There was a written procedure for ambulance staff to follow on arrival at the emergency department. The coordinating nurse in the major treatment area received a brief verbal handover from ambulance staff; however, we noted that they did not always observe the patient. Ambulance crews were then directed to a cubicle space, where an initial assessment was carried out.

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

From December 2017 to November 2018 the monthly percentage of ambulance journeys with turnaround times of over 30 minutes ranged from 47% to 62.8%. This included a noticeable deterioration in performance in February 2018 and March 2018.

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

(Source: National Ambulance Information Group)

Number of black breaches for this trust

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From April 2018 to November 2018 the trust reported 58 “black breaches”.

Fewer black breaches occurred during the summer months, with most handover delays occurring during spring and autumn.
A further 30 black breaches were reported from December 2018 to February 2019.

There were triage and streaming systems in place to identify the sickest patients on arrival in the emergency department and prioritise them for treatment. However, patients were not always assessed promptly on arrival in the emergency department. During our inspection we saw that both patients brought by ambulance and patients who self-presented at the emergency department were assessed promptly. However, the emergency department was not busy during our visit and data showed some variation in assessment times.

**Median time from arrival to initial assessment (all patients)**

The median time (in minutes) from arrival to initial assessment in the year to date (April 2018 to February 2019) was as follows:

Quarter 1 (April to June 2018): 11.00 minutes
Quarter 2 (July to September 2018): 14 minutes
Quarter 3 (October to December 2018): 12 minutes
Quarter 4 (January to 11 February 2019: 14 minutes

Management of crowding and escalation

At our previous inspections, we were concerned about crowding in the emergency department. In particular, we were concerned that patients sometimes waited in the corridor on arrival in the emergency department. During this inspection the department was not busy and the corridor was not used as a clinical area. There was revised guidance on the management of the corridor, which outlined a process of ‘reverse queuing’. This required the coordinating nurse and consultant in charge to identify stable patients, who had been seen, to be cared for in the corridor in order to free up cubicle space for incoming patients, who had not been assessed and did not have a treatment plan. There was an escalation protocol, which required that use of the corridor was sanctioned by senior managers, and which prompted additional support to be identified from within the hospital, or the employment of further agency staff. The trust monitored the use of the corridor for patient care and this was reported at weekly metrics meetings and
was an indicator of crowding. The trust provided us with data which showed 86 patients were cared for in the corridor from December 2018 to February 2019. This amounted to 180 hours. However, this was an improved picture based on the number of times the corridor was used during our previous inspection; with only five, six and zero patients being cared for in the corridor in September, October and November 2018.

There were two hourly reviews of activity in the ED (board rounds) undertaken by the nurse coordinator and the consultant in charge. This ensured they had oversight of the department as a whole and could escalate any staffing concerns through the site management team. There was an escalation card for the ED which set out the different levels of escalation, the triggers for these and the actions to be taken when triggers were met.

**Self-presenting patients**

Patients who self-presented at the emergency department registered at the reception desk and waited to be seen by a triage nurse or an emergency nurse practitioner (ENP), who performed a ‘see and treat’ function. ENPs have additional training which allows them to assess and treat patients without the need for a separate triage. They identified suitable patients and ‘pulled’ these patients from the queue. During our inspection there was a streaming nurse employed at the reception desk, who could direct patients to other services, such as the co-located nurse-led primary care service. They were also able to quickly identify seriously ill or injured patients who needed immediate attention. During our inspection we saw several self-presenting patients, who were prioritised by the streaming nurse and escorted directly to the major treatment area. Staff and managers told us that staff shortage meant that the streaming nurse role was rarely filled. This meant there were missed opportunities to improve patient flow, reduce crowding and improve safety.

Reception staff told us they were experienced and could recognise a patient who needed immediate attention, using their judgement. However, we were concerned that they had received no training and had no written guidance or prompts to aid this decision making. They told us when they asked for help, nursing staff responded quickly. During our unannounced visit we saw some self-presenting patients waited 30 to 40 minutes to be assessed.

**Ongoing monitoring of patient safety and deteriorating patients**

The emergency department used a safety checklist to monitor patients from arrival to discharge. This was a time and sequence-based document that prompted staff to undertake and record patient safety and comfort checks. This was used alongside a nationally recognised early warning tool. Staff used this to identify serious illness, including sepsis, and deteriorating patients, by measuring their vital signs and calculating a score. There were guidelines to prompt staff to escalate concerns to a senior clinician where high scores were present.

The service regularly audited records to monitor the use of the patient safety checklist. There were safety sisters employed from 10am to 10pm to prompt and support staff in its use.

Fifty patient records were audited each month. Overall compliance showed significant improvement, from 52% in February 2018 to 84% in January 2019. However, auditing showed variable performance in relation to compliance with pathways for sepsis, stroke and fractured neck of femur.

During our visits we looked at a small sample of patients’ records. They were mostly completed appropriately; however, we noted that risk assessments for falls were not undertaken or documented. There had been three patient falls reported in the emergency department between November and January 2019. Following a fall in November 2018, staff were instructed to ensure
patients at risk of falls were protected by ensuring they had call bells, they were nursed in cubicles near the nurses’ station and safety rails were used to prevent them falling from trolleys. We did see safety rails were used for some patients but none of the seven records we reviewed had falls risk assessments documented. During our second visit, we noted that two patients had not been given call bells. We could not be assured that the risk of patient falls was being appropriately managed.

During our second visit, a patient who did not have a call bell, asked us to summon a nurse as they were concerned and anxious about their breathing. Although they were close to the nurses’ station there were no staff in the immediate vicinity. We found the nurse in charge, who attended to the patient immediately.

Staff completed risk assessments for pressure ulcers and documented these appropriately. However, during our second visit we noted that one patient had been identified as having existing pressure damage. No steps had been taken to prevent further damage, such as the use of an air mattress.

Staff did not always ensure that patients had identification wristbands. These are important to ensure the right patient receives the right treatment. Staff were prompted by the safety checklist to ensure these were applied in the patient's’ first hour in the emergency department. During our first visits, we accompanied a patient, who was living with dementia, to the X-Ray department. The radiographer carried out an identification check, in accordance with safety protocol and realised the patient did not have a wristband. The patient could not identify themselves or confirm what treatment they were prescribed. The radiographer had to call staff in the emergency department to confirm this. They told us this had been a long-standing problem with the emergency department, although it had improved recently. We saw two patients during our second visit, who did not have an identification wristband.

There was a sepsis screening tool, which was completed by the coordinator or triage nurse, to identify or eliminate the presence of sepsis symptoms. The service audited its use. Audits in November, December 2018 and January 2019 showed the screening tool was used in:

- 19 out of 22 cases of sepsis audited in November
- 20 out of 23 cases of sepsis audited in December
- 12 out of 14 cases of sepsis audited in January

There were plans to introduce a patient group direction to allow registered nurses to administer antibiotics; however, it was noted at the ED governance meeting held in January 2019, that training had been put on hold “until basic care is sorted.” During our second visit we saw that patients with suspected sepsis were identified promptly and the sepsis protocol was used.

During our inspection we saw excellent management of a patient, with a suspected stroke, who was assessed promptly by the streaming nurse and quickly transferred to the major treatment area. A call was put out for the ED senior doctor and the stroke team to attend. A middle grade doctor responded quickly and the stroke team arrived shortly after. The patient was then transferred quickly to the scanning department.

Risk assessment of mental health patients

Staff in the emergency department used a recognised mental health matrix to assess the risk of patients self-harming, harming others or absconding. Those patients who were assessed as requiring an assessment by a mental health practitioner were referred to the mental health liaison service, provided by the local mental health trust and available from 8am to 8pm, seven days a
week. The team was based in the hospital and provided support to the whole hospital but prioritised patients in the emergency department, who they aimed to respond to within one hour. Staff told us they received excellent support from this team, who, we were told had also provided training to some ED staff to support them to risk assess and manage common mental health problems.

Between 8pm and 10pm staff could refer to the community-based intensive support team. Patients awaiting mental assessment were usually cared for in the minor treatment area, where they could be closely observed. Mental Health assessments took place here or in the dedicated mental health assessment room (see premises and equipment above).

There were guidelines in place for the escalation of critically ill or injured children. Support was available from the Seashore children’s unit during the day, Monday to Friday. If a child needed specialist paediatric care, arrangements were made to transfer them to a specialist centre by ambulance. Staff told us if the child was critically ill they contacted a local paediatric retrieval service. Otherwise, they would call 999 and the response was based on the urgency of the child’s needs. Staff reported that there were sometimes long waits. The clinical lead told us that if a child was awaiting transfer at night, the consultant on duty would remain in the department until the arrival of the ambulance. However, we heard of an incident where a child had waited for a prolonged period, which was reported as a “near miss”. Whilst this appeared to be an isolated incident it was not evident that actions had been taken to mitigate the risks of a repeat occurrence.

Emergency Department Survey 2016

The trust scored about the same as other trusts for all the five Emergency Department Survey questions relevant to safety. Responses are scored out of 10.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>6.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.7</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Nurse staffing

The service did not have enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the
right care and treatment.

At the time of our inspection there were 11 registered nurse vacancies in the emergency department and the service was heavily reliant on temporary (bank and agency staff). The service had taken steps to mitigate the risks associated with employment of temporary staff. There were block bookings with agencies to ensure, where possible, there was continuity and premium staffing agencies were used to ensure the employment of staff with appropriate skills and experience in ED. Temporary staff were required to complete an orientation and induction checklist when they started work in the emergency department and this was repeated if they worked in the department infrequently. Staff told us there were some regular bank and agency staff employed and they were confident in the abilities, but told us it was difficult working alongside temporary staff who were unfamiliar with the department. They told us there were sometimes shifts where 50% of the nursing workforce on duty were temporary staff. Data provided by the trust showed this occurred on 12 occasions between 1 December 2018 and 19 February 2019.

Staffing was the biggest concern expressed to us by nursing staff. It was reported at the ED Governance meeting in January 2019 that 18 staffing incidents had been reported in December 2018. The themes were increased pressure, staffing at night and staffing skill mix. We looked at all incidents reported from November 2018 to February 2019. There were 25 incidents reported about staffing concerns, particularly at night, when patients remained in the department after it had closed to admissions. In December 2018 it was reported that there was no nurse allocated to care for patients in the corridor for two hours. The front door matron’s annual review of staffing (March 2019) reported that there was under-reporting of staffing concerns.

The emergency directorate risk register recorded a lack of ED nursing staff as a high risk. Controls in place included:

- Daily staffing meeting
- Agency control forms
- Block booking of agency staff
- Daily skill mix reviews

The front door matron had recently completed an annual review of nurse staffing in ED. The report, which was still in draft at the time of our inspection, concluded that the emergency department had an appropriate staffing establishment but there was need to review the skill mix and shift patterns as currently this did not match the attendance profile. It was noted that a high proportion of incidents and complaints were attributed to staffing levels and skill mix. There were particular concerns highlighted about staffing in the minor treatment area, where, it was reported, patients with an undifferentiated diagnosis could wait up to four hours to be assessed and treated by a doctor or an ENP. It was noted that these patients were triaged but there was a risk their condition could deteriorate while they were in the waiting room. These concerns mirrored concerns described to us about staffing in the minor treatment area. During our second visit, we were told by the safety sister at 9.30 pm that the waiting time for patients to be seen in the minor treatment area was three hours and 40 minutes. The safety sister was supporting staff but felt there were insufficient staff to ensure patients were seen in a timely way.

There were band seven safety sisters employed daily from 10am to 10pm. They provided support to nursing staff. They carried bleeps and staff could contact them for advice and
support. They also carried out hourly safety checks.

The emergency department employed two part-time registered children’s nurses; this did not enable them to ensure there was always a suitably qualified nurse to care for sick children. We asked the trust to provide details of training provided to adult-trained nurses to ensure they were confident and competent to care for sick children. They provided only data to show how many staff had completed paediatric immediate life support training (87% of registered nurses) and advanced paediatric life support training (37%) of registered nurses. The safety sisters monitored the availability of a paediatric-trained nurse for each shift and reported also on the number of times staff called on the support from the children’s centre. Data showed there were 14 occasions in January 2019 and 11 occasions in February 2019 (up to 20 February). Five of these absences occurred at weekends when there was no support available from the children’s centre. A consultant told us the aim was to ensure there was always a nurse trained in advanced paediatric life support training on duty as well as a senior doctor. They told us they had not quite achieved this in relation to nursing staff (see mandatory training above). This was monitored and reported on at the weekly metrics meeting.

The trust reported the following registered nursing staff numbers for March 2018 and November 2018 for urgent and emergency care. Fill rate had dropped by nearly 14 whole time equivalent (WTE) (30%) between the two months.

<table>
<thead>
<tr>
<th>Location</th>
<th>March 2018</th>
<th>November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned WTE</td>
<td>Actual WTE</td>
</tr>
<tr>
<td>Emergency department</td>
<td>43</td>
<td>34.7</td>
</tr>
</tbody>
</table>

(Source: Additional data provided by the trust following factual accuracy process)

**Vacancy rates**

From December 2017 to November 2018, the trust reported a vacancy rate of 27.8% for registered nursing staff in urgent and emergency care. This was higher than the trust target of 8% and the trust average of 15.7%.

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

**Turnover rates**

From March 2018 to February 2019 the trust reported a turnover rate of 27% for registered nursing staff in urgent and emergency care. This was higher than the trust target of 15%. We asked the trust for data to show the reasons for this high level of turnover but this was not provided. The trust subsequently advised that the reasons for high turnover were uncertainty about the future of the department and a lack of training and development opportunities.

(Source: DR134 ED Turnover)

**Sickness rates**

From December 2017 to November 2018, the trust reported a sickness rate of 3.6% for registered nursing staff in urgent and emergency care. This was lower than the trust target of 3.9%.

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

**Bank and agency staff usage**
From December 2017 to November 2018, the trust reported that 4.2% of qualified nursing shifts in urgent and emergency care were filled by bank staff and 24.1% of shifts were filled by agency staff. In addition, 3% of shifts were not filled by bank and agency staff to cover staff absence.

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

Handover

There was a structured handover at the beginning of each shift. This followed a standard format and included information about staffing levels, capacity and waiting times, equipment checks and reminders about identifying patients who were suitable to be seen by the frailty team or to be referred to the ambulatory emergency care department.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

There were 6.7 whole-time equivalent (WTE) consultants employed. There was consultant presence in the emergency department from 8am until midnight, seven days a week. They worked overlapping shifts from 8am until 6pm and from 4pm until midnight. The Royal College of Emergency Medicine recommends that 12 consultants are required to cover 8am to midnight seven days a week, so we questioned whether this rota was sustainable.

There were 7.25 WTE middle grade (doctors were not in training positions) employed. There was ongoing recruitment to employ more. In the meantime, gaps in the rota were covered by locum doctors. All middle grade doctors had membership of the College of Emergency Medicine, a postgraduate qualification, but it was acknowledged by the clinical lead that some overseas doctors had gaps in their knowledge, confidence and language skills. There was a programme of education and mentorship to support them with this. For this reason, they were viewed as independent practitioners and did not supervise junior doctors. Junior doctors were instructed to seek advice from consultants.

There were seven trainee doctors; four foundation year 2 (FY2) doctors and two general practice vocational training scheme trainees. Each trainee doctor had an educational supervisor and always worked under the supervision of a consultant.

Some junior medical staff expressed serious concerns about the competence of some senior medical staff and told us at times they felt unsupported and vulnerable. They told us they had reported their concerns; there were regular meetings with the clinical lead. It was acknowledged that the experience of junior doctors was improving but some junior doctors still described looking at their rota in trepidation, anxious that they may be working with senior staff whom they perceived to be less supportive or competent.

We spoke with five junior doctors. All but one expressed some concerns, some more serious than others. The clear message was that they felt less confident when certain consultants and/or middle grade doctors were on duty. We heard about three incidents, where junior staff were treating very sick patients and they felt out of their depth and unsupported, and had to refer to senior medical staff outside of the ED for advice. These had not been reported through the incident reporting system and when we asked the clinical lead to provide evidence of dialogue with junior medical staff and investigation of concerns, they could only provide minutes of one meeting, which took place in January 2019.
One junior doctor told us that one of the consultants regularly absented themselves from the emergency department without informing their colleagues. An incident was reported in February 2019 because the ED consultant on duty could not be found and was needed for advice. Several junior doctors expressed concerns about a lack of engagement and proactive supervision from another consultant. We discussed these concerns with both the clinical lead and the trust’s medical director. They told us that appropriate actions had been taken to address these concerns. However, they could not provide us with evidence to show that these concerns had been appropriately managed.

All of the junior doctors we spoke with reported that the clinical lead was supportive, and the two newly-appointed locum consultants were described as very competent and “a breath of fresh air.”

One junior doctor told us they did not feel confident or competent to care for sick children. They had not been able to access the paediatric simulation training provided.

At our last full inspection, we identified concerns about the lack of skills in relation to caring for sick children. There was no consultant with paediatric skills on duty in the hospital overnight or at weekends. During weekdays support was available from the Seashore children’s day care unit. This was not available overnight or at weekends.

The ambulance service took children to other centres out of hours; however, children were sometimes brought in by their parents. The ED risk register previously identified a risk in relation to paediatric resuscitation events and whether staff had the necessary skills.

We reviewed this at our most recent inspection and spoke with the consultant paediatrician, who felt that the risk was mitigated by the emergency department closure overnight. They told us very few sick children were brought in by their parents as the local population understood the limitations of the department. They told us that all middle grade and consultant staff were trained in advanced paediatric life support. Data provided by the trust, however, showed this was not the case (see mandatory training).

**Staffing skill mix**

In September 2018, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher. Notably the trust reported no registrars within urgent and emergency care in comparison to the England average of 34%. Middle grade doctors were employed in non-training roles.

**Staffing skill mix for the 18 whole-time equivalent staff working in urgent and emergency care at Weston Area Health NHS Trust.**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>26%</td>
<td>30%</td>
</tr>
<tr>
<td>Middle career</td>
<td>47%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar group</td>
<td>0%</td>
<td>34%</td>
</tr>
<tr>
<td>Junior*</td>
<td>27%</td>
<td>22%</td>
</tr>
</tbody>
</table>
Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2
(Source: NHS Digital Workforce Statistics)

Records

Staff kept detailed records of patients’ care and treatment. Records were mostly clear, up-to-date and easily accessible to all staff providing care.

Patients’ records were stored in patients’ cubicles or in locked storage trolleys.

We looked a sample of patients’ records during our visits. The standard of record keeping was variable, according to the staff member completing them. We noted the safety checklist was not always completed contemporaneously. Staff marked tasks as complete, by writing their initials next to the task. We saw that some tasks were initialled at the same time and up to an hour retrospectively.

We looked at three patients’ records during our first visit. Record keeping was generally good but staff did not consistently sign and date entries or document their designation. We looked at four sets of patients’ notes during our unannounced inspection. Three out of four had safety checklists completed appropriately, although there were a few unexplained gaps. None had a risk assessment for falls completed and two did not record that a patient identification wristband had been applied. The fourth record had not been completed for over an hour. In one record we noted that a doctor had written up a review of the patient but had not signed, timed or dated the entry.

A sample of safety checklists was audited daily by the safety sister. A total of fifty records were audited each month. Overall compliance with record keeping standards was 84% in January 2019.

Staff were able to view patients’ hospital history and imaging and test results electronically. Staff told us they generally had no problems accessing the information they required. Emergency department staff were not able to view patients’ records relating to their care and treatment by the local mental health trust, although there were plans for this to happen. They could, however, obtain relevant medical history via the mental health liaison team. Mental health liaison staff could access patients’ ED records.

There were a number of care and treatment plans, jointly developed by ED doctors and mental health specialists, for patients with mental health needs who were frequent attenders at the emergency department. These were held in a folder in the staff room, so were not easily
accessible by, for example, triage staff. There were plans to make this information available electronically.

**Medicines**

The service followed good practice when prescribing, giving, recording and storing medicines.

There were suitable arrangements for the storage of medicines, including controlled drugs. Medicines were stored securely with access restricted to nursing staff. However, access to medicines requiring disposal was not restricted to authorised staff. Medicines requiring disposal were not locked away and non-clinical staff had access to the treatment room where they were stored. There was an electronic key system used to access drug cupboards; however, staff reported that this system was “temperamental” and this could cause delays in accessing medicines.

Fridge temperatures were recorded daily and action had been taken when temperatures were out of range. However, room temperatures were not monitored. The trust’s medicines policy stated that the ambient temperature for the storage of medicines should be monitored regularly and should not exceed 25 degrees. An incubator was used to heat up lidocaine, however, staff were not aware what temperature it was stored and had no assurance it was appropriate.

There were suitable arrangements for the storage and management of controlled drugs. A stock balance was completed daily by two nurses. Quarterly audits of controlled drugs were completed by pharmacy staff.

Blank prescription pads were stored securely and there was a system in place to monitor their use.

Emergency medicines were available and were stored securely, sealed and checked regularly. Resuscitation trolleys were checked daily and monthly and trolleys were sealed to ensure they were tamper-evident. The clinic room temperature was not being monitored and some medicines were being stored in an incubator but there was no assurance that medicines were stored at an appropriate temperature. Some medicines, which had a reduced shelf life once opened or removed from the fridge, did not have an updated expiry date to ensure they were still safe to use.

Patient group directions (written instructions which allow suitably trained clinicians to administer certain medicines to certain groups of patients, without the need for a prescription from a doctor) had expired in August 2017 and were currently being updated, so were not in use. This meant all medicines had to be prescribed by a doctor.

There was no pharmacist employed in ED, although a pharmacist had just been recruited to support the frailty team. The central pharmacy stores team completed weekly stock top-ups and pharmacists were involved in reviewing stock held.

**Incidents**

The service did not manage safety incidents well. Incidents were not always investigated in a timely way and there was a lack of assurance that appropriate remedial actions had been taken and fed back to staff.

Staff understood their responsibility to report incidents and told us they were encouraged to do so. However, some staff told us they did not receive feedback.
Managers investigated incidents and told us they monitored them to identify themes and learning. However, when we asked the ED management team to describe any learning from serious incidents they could not think of any examples to share with us. They told us that incidents were discussed at ED governance meetings. We reviewed the minutes from these meetings held in November and December 2018 and January 2019 and saw very little analysis or identification of learning to be shared, although in January there was a reminder to staff to check early warning scores of patients being admitted. It was noted at the meeting in January 2019 that there were 174 outstanding incidents in the emergency department at 31 December 2018.

We looked at all incidents reported from November 2018 to January 2019. The information provided to us by the trust was in the form of a spreadsheet, which included actions taken to prevent reoccurrence and lessons learned. It also indicated whether the incident reports had been approved. Information was not always complete so we could not be assured if necessary remedial actions had been taken. For example, in November 2018 it was reported that a patient was discharged from ED with another patient’s details on their prescription form and had been prescribed a medicine which they were allergic to. There were no actions or lessons learned recorded and the approval status was marked as “local action”. Also in November 2018, there were two incidents reported where junior medical staff felt bullied, unsupported and spoken to inappropriately. Again, there were no actions or lessons learned and the approval status was “local action”. In December 2018, it was reported that a doctor gave a prescription with the wrong patient label to a nurse. There were no actions or lessons learned recorded. There was no discussion recorded at governance meetings about these or other incidents.

The service had taken some steps to cascade learning from incidents. There was a closed social media platform used to communicate important issues to staff, which included learning from incidents. There was an ‘incident of the month’ selected; during our visit the topic was removal of patients’ cannula on discharge. There had been a number of incidents in the preceding months where patients had left the department with cannulas in situ. Nursing staff were reminded at daily ‘safety huddles’ to check that patients’ cannulas were removed and to document this in their records. We noted however, that this was the selected incident of the month for January. We visited in February and March and this message had not changed.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From December 2017 to November 2018, the trust reported no incidents classified as never events for urgent and emergency care. However, a never event was reported in December 2018, which involved administration of the incorrect dose of Midazolam, resulting in overdosation of a patient. A 72-hour report had been produced, which described initial findings and actions taken. The patient came to no harm and the care and treatment after the event was appropriate. A full root cause analysis was underway at the time of our inspection.

(Source: Strategic Executive Information System (STEIS))

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 12 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from December 2017 to November 2018.
Treatment delay meeting SI criteria (four serious incidents) and sub-optimal care of the deteriorating patient SI criteria (three serious incidents) accounted for most of the serious incidents reported to STEIS.

(Source: Strategic Executive Information System (STEIS))

Seven of these serious incidents were still under investigation or with executive managers for review and sign off, including one incident which was reported in March 2018, almost 12 months previously.

**Mortality and morbidity reviews**

The service did not hold regular mortality and morbidity meetings to review deaths and other unexpected outcomes. This review was a standing agenda item at the ED governance meeting but nothing had been discussed at the meetings held in November and December 2018 and January 2019. In November 2018 it was recorded “Nothing to report, still under discussion with [clinical lead] and [consultant].” In December it was recorded as “still outstanding” and in January 2019 it was recorded that “[consultant] would raise at the next ED consultants’ meeting.”

This issue was recorded on the emergency directorate risk register as a moderate risk.

**Safety thermometer**

The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

Data from the patient safety thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from November 2017 to November 2018 within urgent and emergency care.

(Source: NHS Digital - Safety Thermometer)

**Is the service effective?**
Evidence-based care and treatment

Although staff could access care and treatment protocols based on national guidance and best practice, we had concerns about version control and out of date guidelines. This meant there was potential for medical staff to access out of date guidelines.

Aside from participation in national Royal College of Emergency Medicine (RCEM) audits, the service did not routinely monitor compliance with national guidance, so we could not be assured they were complied with.

Medical staff could access treatment protocols and guidance via the intranet and there were also paper copies available. There was an ED folder on the internal shared drive; however, not all protocols stored here were up-to-date. Medical staff we spoke with were aware of this and found guidance on the trust-wide intranet. For example, in the ED folder (shared drive) we found a guideline for diabetic ketoacidosis (DKA - a serious problem that can occur in people with diabetes if their body starts to run out of insulin), which was dated 2007. A junior doctor found a DKA policy on the intranet, which was more up-to-date, although, dated 2016 and the review date (December 2018) had passed. We found another trust clinical guideline for diabetic sick days, which was dated 2008, with a review date of 2011. We were concerned that there was the potential for medical staff to access out of date guidance. One consultant told us there were plans to streamline treatment guidelines and protocols, to ensure they were available in one place.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

Staff were prompted by the safety checklist to provide food and drinks to patients. Audits of checklists showed in the last six months staff offered refreshments to patients within two hours of admission to the emergency department most of the time. Compliance with this standard ranged between 94% and 100%. Fluid balance charts were also used when necessary to monitor patients’ fluid intake and output.

Volunteers worked in the emergency department and assisted to provide refreshments to patients. Sandwiches and hot and cold drinks were provided as required. Staff told us that they were not able to access hot meals for patients who remained in the department for a long period of time, including overnight. The trust subsequently advised us that hot meals could be ordered via the medical assessment unit.

Emergency Department Survey 2016

In the CQC emergency department survey, the trust scored 7.3 out of 10 in response to the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Pain relief

Staff assessed and monitored patients to see if they were in pain and offered timely pain relief. However, pain scores for children were not consistently recorded, although the service was taking steps to improve this.

Staff were prompted to assess pain and record a pain score on the safety checklist, used for all patients in the major treatment area. Monthly audit of safety checklists showed that generally this was done well.
There was a pictorial pain assessment tool which staff could use to assess pain in children or adults with cognitive or communication difficulties. This was displayed in the triage room for staff to refer to.

Audits of safety checklists (50 each month) included checks to ensure staff assessed and recorded assessment of pain and timely administration of pain relief. In November and December 2018 and January 2019, the service scored between 98% and 100% for pain assessment at triage, between 92% and 100% for pain relief administered at triage, between 83% and 96% for pain assessed hourly and between 78% and 100% for pain relief administered within time limits.

Weekly audits of children’s records highlighted that staff did not always record a pain score. Between 24 December 2018 and 17 February 2019 pain scores were recorded in between 50% and 83% of cases audited, although this was showing an improving trend.

**Emergency Department Survey 2016**

In the CQC emergency department survey, the trust scored 6.3 out of 10 in response to the question “How many minutes after you requested pain relief medication did it take before you got it?” This was about the same as other trusts.

The trust scored 8.1 out of 10 in response to the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

*(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)*

**Patient outcomes**

The service monitored the effectiveness of care and treatment but there was limited evidence to show that they used their findings to improve outcomes.

The service participated in national Royal College of Emergency Medicine (RCEM) audits so that it could compare local results with those of other services to learn from them. There was a designated consultant lead for audit, who was appointed to this role in 2018. He was not familiar with the audits reported below, which took place in 2016/17 because these audits had not been handed over to him. The trust audit manager confirmed to us that no action plans had been submitted for these audits so we could not be assured that there was any learning from them.

**RCEM Audit: Moderate and acute severe asthma 2016/17**

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, Weston General Hospital’s emergency department failed to meet any of the national standards.

However, the emergency department was in the upper UK quartile for all seven standards:

- **Standard 1a (fundamental):** Oxygen should be given on arrival to maintain oxygen saturation 94-98%. This department: 92%; UK: 19%.
- **Standard 2a (fundamental):** As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 62%; UK: 26%.
- **Standard 3 (fundamental):** High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 96%; UK: 25%.
- **Standard 4 (fundamental):** Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. This department: 97.1%; UK: 77%.
• Standard 5: If not already given before arrival to the emergency department, steroids should be given as soon as possible as follows:
  o Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
  o Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
  o Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV

• Standard 5a (fundamental): within 60 minutes of arrival (acute severe). This department: 42.9%; UK: 19%.

• Standard 5b (fundamental): within 4 hours (moderate). This department: 59.5%; UK: 28%.

• Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as follows:
  o Adults 16 years and over: 40-50mg prednisolone for 5 days
  o Children 6-15 years: 30-40mg prednisolone for 3 days
  o Children 2-5 years: 20mg prednisolone for 3 days

This department: 94.4%; UK: 52%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Consultant sign-off 2016/17

In the 2016/17 Consultant sign-off audit, Weston General Hospital’s emergency department failed to meet any of the national standards.

The department was in the upper UK quartile for three standards:

• Standard 1 (developmental): Consultant reviewed: atraumatic chest pain in patients aged 30 years and over. This department: 20.8%; UK: 11%.

• Standard 3 (fundamental): Consultant reviewed: patients making an unscheduled return to the emergency department with the same condition within 72 hours of discharge. This department: 26.7%; UK: 12%.

• Standard 4 (developmental): Consultant reviewed: abdominal pain in patients aged 70 years and over. This department: 25%; UK: 10%.

The department’s results for the remaining one standard was within the middle 50% of results.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Severe sepsis and septic shock 2016/17

In the 2016/17 Severe sepsis and septic shock audit, Weston General Hospital’s emergency department failed to meet any of the national standards.

The department was in the lower UK quartile for three standards:

• Standard 1: Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. This department: 46%; UK 69.1%

• Standard 2: Review by a senior (ST4+ or equivalent) ED medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED.
This department: 44%; UK 64.6%

- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival: This department: 6%; UK: 18.4%
- The department’s results for the remaining five standards were all within the middle 50% of results.

(Source: Royal College of Emergency Medicine)

The management of sepsis was monitored monthly on an ongoing basis. Audits conducted in November and December 2018 and January 2019 showed:

- In November antibiotics were administered within one hour in 66% of cases audited.
- In December antibiotics were administered within one hour in 82% of cases audited.
- In January antibiotics were administered within one hour in 61% of cases audited.

The service had participated in three further audits in 2017/18. These were fractured neck of femur, pain in children and procedural sedation. The audit results, published in July 2018, were displayed in the emergency department and staff were encouraged to read them. No action plans had been produced in response to these audits.

Procedural sedation

The audit lead told us he had not been directly involved in the audit of procedural sedation, in which the trust had performed poorly, although there were only four cases audited. The only actions arising from this audit were the placement of an emergency department monitoring chart (dated 2015 and not reviewed in light of recent audit) on the ED section of the intranet and an email to staff, signposting them to this and encouraging them to use it. There were no plans to audit this further or seek assurance of the competence of staff in this procedure. The proforma stated that sedation of patients under 16 should only be performed by a consultant or middle grade doctor.

We spoke with one consultant, who was aware of the proforma and where to find it. They advised us there was an agreement that patients under 16 would not be sedated; this was confirmed by the audit lead; therefore, the proforma was out of date and misleading.

We spoke with a middle grade doctor, who was not sure where to locate the proforma, but did find it for us. They had not performed sedation since they had been employed in the emergency department (over a year). A second middle grade doctor, employed for approximately seven months also confirmed they had not performed sedation.

We could not be assured that all senior doctors had the knowledge and experience to perform sedation safely.

The trust had performed well in the Royal College of Emergency Medicine (RCEM) fractured neck of femur audit and results were mostly above the national average.

We did not review the pain in children audit.

The audit lead told us that trainee doctors were encouraged to take part in audit. They told us about a recent paracetamol audit which had been undertaken and provided us with the audit report; however, no action plan had been completed in response to this. Audit was included as a standard agenda item at the ED clinical governance meeting but the clinical audit lead was unable to find any minutes where specific audits or action plans were discussed. We noted in the minutes for the meetings in November and December 2018, it was recorded that the trust
had registered for the 2018/19 RCEM audits. The trust audit manager told us the trust had registered late because there had been a delay in identifying funding. This was a recurring issue, which had not been resolved. It was acknowledged by the audit lead that late registration for the audits, which were launched in August 2018, reduced the amount for time for data collection.

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

From December 2017 to November 2018, the trust’s unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% but better than the England average.

In the most recent month, November 2018, trust performance was 6% compared to an England average of 8%. This could indicate that care and communication delivered during the first attendance was not satisfactory, and should be investigated. This was not discussed at ED governance meetings in November or December 2018 or January 2019.

**Unplanned re-attendance rate within seven days - Weston Area Health NHS Trust**

![Graph showing unplanned re-attendance rate](image)

(Source: NHS Digital - A&E quality)

Performance was 6.07% in December 2018 and 5.86% in January 2019.

(Source DR21 February 2019 PowerPoint)

**Competent staff**

The service did not have effective systems to ensure that staff were competent for their roles. There was no oversight of nursing staff ED-specific competencies. We were not assured that poor staff performance was well managed, and staff supported to improve.

**Medical staff**

Information provided to us by the trust at the time of our inspection showed that only 75.7% of medical staff employed in the emergency department as at January 2019 had received a performance appraisal. Given some of the concerns expressed to us by junior doctors about clinical competence, confidence and behaviour of some of their senior colleagues, this was concerning.
Several junior doctors reported concerns about the clinical competence of some senior doctors. Whilst senior staff told that these concerns were taken seriously and acted upon, the trust was unable to provide evidence to demonstrate this.

Some middle grade doctors, who had not trained in the UK were completing training to allow them entry to the specialist register, a requirement in order to progress to consultant grade. However, one middle grade doctor, who had been recruited with a commitment to support them to pursue this training route, told us they had not been able to access the relevant training and experience because the emergency department was so busy and there were gaps in the rota. They were disillusioned and had decided to leave.

Junior medical staff received protected time for teaching. In addition to structured weekly training, each day, there was an afternoon handover, where five minutes were dedicated to teaching. Trainees were asked to present cases to their colleagues on a rotational basis - these were known as ‘five-minute wonders’ and a prize was offered for the best presentation. This allowed junior doctors to share cases which had been challenging for them and to share their learning with junior and senior colleagues. Junior doctors told us they found these sessions helpful.

The clinical lead met with a junior doctor representative each month to discuss any concerns with regard to their placement, training and supervisions. Only one of these meetings had been recorded, but junior doctors told us they appreciated this opportunity.

**Nursing staff**

Nursing staff did not receive regular supervision, either one-to-one or group supervision. There was no evidence provided to us of a training needs analysis carried out to identify and meet ED-specific competencies for registered nurses and healthcare support workers. There was no practice development nurse; currently the coordination and oversight of nurse training was the responsibility of the senior sister. They had developed a competency checklist and issued this to nursing staff in August 2018; however, this was not supported by a policy or process, which outlined what was expected of staff, how competencies were to be assessed and signed off and how the service was going to monitor this. There was therefore no formal assurance that staff were fully equipped to undertake their roles. The front door matron had completed a staffing review (March 2019) and had recommended the appointment of a practice development nurse. Exit interviews conducted with staff who had recently left the organisation had identified that staff felt they did not receive adequate training or support. Following our inspection, the trust advised us that the recommendation to appoint a practice development nurse had been agreed in April 2019.

A newly qualified nurse told us they had been allocated a mentor, but they rarely worked alongside them; there had been no formal review of their competencies since joining the emergency department. They told us they sometimes felt they were asked to perform procedures, which they had not received training to perform. On one occasion they had sought support from a senior nurse, to undertake a task they felt anxious about. The senior nurse had refused to support them. This made them feel vulnerable and unsupported.

An incident was reported in November 2018 where a patient’s treatment was delayed because the allocated nurse was not able to set up bilevel positive airway pressure, known as BIPAP (non-invasive ventilation), because they were unfamiliar with this procedure. The patient was felt to have received sub-optimal care, owing to the delay. One of the actions arising from this incident was to ensure all staff in ED were competent to set up BIPAP and be confident in its management, but no assurance was evident that this had been addressed. The incident was not discussed or noted at governance meetings held in November and December 2018 or January
2019. Some staff told us that they would contact the senior sister for support if they felt they were not trained or confident to carry out a task.

A breakdown of appraisal rates for nursing staff and health care assistants from December 2017 to November 2018 is shown below. The trust target for completion of appraisals is 85%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals complete</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered nurses</td>
<td>49</td>
<td>46</td>
<td>93.9%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>24</td>
<td>18</td>
<td>75.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Appraisal tab)

**Multidisciplinary working**

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

Staff in the emergency department told us they received good support from the medical registrar, who was based in the emergency department and was responsible for reviewing medically expected patients, although a number of incidents had been reported about delayed medical review, particularly at night.

We saw excellent teamwork with the hospital’s stroke team, frailty team and psychiatric liaison team. There was a written agreement with the children’s centre outlining the support they were able and willing to provide.

**Seven-day services**

**There was not a full range of services available seven days a week.**

X-ray and CT scanning services were available 24 hours a day, seven days a week although staff reported some delays out of hours for CT scans as staff were on call only. MRI scans were available Monday to Friday (9am to 5pm) only.

The stroke team was available to support the emergency department Monday to Friday only from 8.30 am to 4.30pm. Patients who required thrombolysis outside of these hours were diverted to Bristol or Taunton.

Pharmacy support was available during daytime hours Monday to Saturday and an on-call service was available on Sundays and out of hours.

Allied health professionals, including therapists were available during working hours Monday to Friday.

There was a mental health liaison service provided by the local mental health trust, which operated seven days a week from 8am to 8pm. Outside of these hours, ED staff could refer patients rated red (high risk) or amber (moderate risk) to the community-based intensive support team.

**Health promotion**

**The service had taken some steps to support people to live healthier lives.**

Patients identified as smokers or those who were alcohol or substance-dependant could be referred to ‘stop smoking’ services and alcohol and drug addiction services.
Patients were supported to manage other aspects of their health. Staff could refer patients to other services, such as diabetes services.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff demonstrated poor understanding about how and when to assess whether a patient had the capacity to make decisions about their care and treatment. Most staff groups were not compliant with the 90% target for attendance at mandatory training in the Mental Capacity Act (MCA).

There was guidance on the MCA and consent, available on the intranet and this was also available in a resource folder in the emergency department. Many aspects of care and treatment were provided with informal or implied consent. We heard nursing and medical staff explain to patients the tests and procedures before carrying them out. However, a significant number of patients seen in the emergency department had some form of cognitive impairment and were unable to understand proposed treatments or interventions or consent to them.

During our first visit we reviewed the records of a patient living with dementia. There was no evidence of a mental capacity assessment for this patient or evidence that consent was sought for an X-ray to be performed. During our second visit, we reviewed the records for three elderly patients, where it was not clear whether they had capacity or not. It was recorded that these patients were living with dementia. Two patients were recorded as having full capacity, the third was recorded as having no capacity. There was no documentation to demonstrate how this conclusion had been reached. A number of staff at all levels, including a consultant, did not know where to locate a mental capacity consent form. This is required where a decision about care and treatment needs to be made. This was immediately located for us by another consultant.

Staff were knowledgeable about gaining consent in relation to children. We observed staff clarify with accompanying adults that they were the child’s legal guardian and they sought consent from them to perform care and treatment. This was done with the involvement of the child where possible. One out of two nursing staff we asked were familiar with Gillick competence. The Gillick test is a tool which can be used to assess whether children under 16 have the capacity to consent to treatment. The other staff member told us they would defer to a doctor.

Mental Capacity Act and Deprivation of Liberty training completion

The trust reported that as of February 2019 Mental Capacity Act (MCA) training was completed by:

- 83% of senior medical staff
- 100% of junior medical staff
- 73.6% of band 5 or below nurses
- 75% of band 6 or above nurses

Over the same period Deprivation of Liberty Safeguards training was completed by 71.6% of staff in within urgent and emergency care compared to the trust target of 90%.

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

Is the service caring?

Compassionate care

Staff cared for patients with compassion.
Feedback from patients confirmed that staff treated them well and with kindness. Staff took the time to interact with patients in a respectful, considerate and friendly manner. We observed staff introduce themselves by name and their role. The tone of voice they used was caring and compassionate and appropriate to each patient’s emotional state and needs. We observed staff using humour to engage and build a relationship with patients, as well as take their mind off their discomfort or anxiety.

During our second visit the emergency department was extremely busy. Despite this, staff took time to care. We observed an elderly patient looking a bit lost. They were looking for the toilets and a consultant, despite being very busy, offered to escort them there.

We spoke with patients and looked at thank you cards received by the emergency department. Comments included, “thank you for all the help, support, skill and compassion”, “excellent care and attention from all concerned” and “all the staff have been wonderful, friendly and helpful”.

However, during our second visit, the emergency department was cold; staff had not taken steps to check on patients’ comfort and offer them blankets. We observed an elderly patient waiting by the entrance to the emergency department waiting room. There were no chairs available for this patient to be seated and their carer was rubbing their hands to keep them warm.

Staff respected people’s privacy and dignity. We saw staff took care to pull curtains or close doors to ensure patients some privacy.

**Friends and family test performance**

The trust’s urgent and emergency care friends and family test performance (% recommended) was about the same as the England average from December 2017 to November 2018.

In the most recent month, November 2018, trust performance was 84.7% compared to the England average of 86.6%.

**A&E Friends and Family Test performance - Weston Area Health NHS Trust**
Emotional support

Staff provided emotional support to patients to minimise their distress.

Staff recognised and responded to patients’ anxiety. We observed staff explaining procedures to patients in a way which was reassuring. We observed staff communicate with patients in non-verbal ways to provide comfort, such as holding their hand or rubbing their arm.

We observed a staff member supporting and reassuring a patient who was anxious about the safe keeping of their personal belongings. The staff member took the time to reassure the patient and explain the actions they would take to ensure their belongings were secure and repeated this information several times to ensure the patient fully understood and was reassured.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

All patients we spoke with told us they were aware of the treatment they were receiving and why. Relatives and carers also reported they felt involved in care and decisions where appropriate. Patients told us they were given time to ask questions and did not feel rushed.

We observed staff take the time to explain to a parent why a certain type of treatment was not required for their child. They clearly explained the reason behind this and ensured the parent felt comfortable with the decision made. They also acknowledged the parent’s concern about whether they should have brought their child to the emergency department. They reassured the parent and explained they were there to offer help and advice when needed.

Emergency Department Survey 2016

The trust scored about the same as other trusts for all of the 24 Emergency Department Survey questions relevant to the caring domain.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing, and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>7.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>7.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>5.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>5.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>5.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals</td>
<td>5.7</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Is the service responsive?

Service delivery to meet the needs of local people

The service did not always meet the needs of local people.

Patients who were suspected to have suffered a stroke and required thrombolysis treatment were diverted to Bristol after 4.30 pm on weekdays and at weekends. Patients who required cardiac catheterisation were also diverted to Bristol or Taunton.

Children were diverted or transferred Bristol or Taunton after 8pm on weekdays and at weekends.

Premises and facilities were not wholly appropriate. The emergency department was frequently crowded. Patients in ED were not always accommodated in the most appropriate area of the department when it was crowded. When there were no available cubicles in the department, some patients were cared for in the corridor. There were temporary curtains positioned in this area to ensure some privacy and patients were given call bells. There were notices to patients to reassure them that their care would not be affected because they were in this transitional area. Patients were sometimes accommodated in the emergency department for long periods of time, including overnight. This was not an appropriate environment, with limited access to washing facilities and hot meals.

During our second visit the temperature in the emergency department was not appropriate, particularly for patients in a state of undress. Two patients in the major treatment area told us they were cold and requested a blanket. One patient had covered themselves with a dressing gown to try to get warm. When we drew his to the attention of staff, they immediately fetched blankets and made the patients comfortable.

The emergency department was well signposted from the main entrance to the hospital. The carpark was close and there was a drop off zone, where visitors could park for a limited time. There were large notices advising the public that the emergency department was not open between 10pm and 8am.

The waiting area had been reconfigured and updated since our last inspection. It was a clean and bright space, well-equipped with adequate comfortable seating. During our first visit, there was adequate seating for patients and visitors; however, during our second visit, by 9pm the waiting room was full. Some patients and visitors had to stand; others found hospital wheelchairs to sit in. The waiting area was also very cold during the evening. We saw one patient had asked for a blanket and we saw a carer rubbing a patient’s hands to keep them warm.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>regarding your illness or treatment to watch for after you went home?</td>
<td></td>
<td>as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)
The reception desk was suitable for patients who used a wheelchair. There was a hearing loop to support people who used a hearing aid.

Patients could discuss their condition with staff without being overheard. Since our last inspection, the department had introduced a room, adjacent to the main reception which could be used by patients who did not want to disclose the reason for their attendance in an open area. It could also be used for patients who felt they needed a quiet place to wait if they found the busy waiting area distressing. However, there were no signs to advise patients and visitors that this was available. We spoke with a patient who had attended the emergency department on numerous occasions. They said they sometimes found it uncomfortable discussing the reason for their visit with the receptionist, when there were people queuing behind them.

There was information displayed on the walls of the waiting area, which explained to patients what to expect and the various pathways through the emergency department. Estimated waiting times were also displayed. However, during our second visit, when patients were waiting more than three hours to be seen, patients told us they had not been informed and were not aware of how long they may have to wait. At approximately 9pm a senior nurse made an announcement in the waiting room, apologising for the long wait and advising patients, if their condition was not urgent, they could return in the morning. There were vending machines where patients and visitors could buy drinks and snacks and a free phone kiosk to order a taxi.

There was a separate waiting area for children. This was appropriately decorated and equipped with a range of toys for small children. However, the room was small and could not easily accommodate families with pushchairs. We noted that it was not used frequently during our inspection, with families preferring to sit in the main waiting area. One treatment cubicle had been decorated to create a child-friendly clinical environment.

There was a private room available for nappy changing and infant feeding.

There was a relatives’ room, which had been sensitively decorated and furnished and could be used by distressed or anxious relatives who required a quiet place to wait.

Children were diverted or transferred Bristol or Taunton after 8pm on weekdays and at weekends.

There was a large elderly population in Weston, estimated to be 10% higher than the national average. In response to this, and to help manage patient flow, by avoiding unnecessary hospital admission, the trust provided a frailty service. A frailty team, consisting of a part time consultant (two days a week), nurse specialist and physiotherapist, saw patients over 75 years of age, who met agreed criteria. Ambulance staff bringing elderly patients into ED assessed them, using a frailty tool and shared their assessment, using a frailty score, with ED staff on arrival. There were plans to expand the frailty service to operate five days a week. Staff in ED were very positive about the contribution this service made; the frailty team were similarly very proud of their service and had a very clear vision of how it would continue to grow. The service was however, limited by a lack of suitable space in which to assess their patients and was currently available only two days a week, although further staff had been recruited and the service was to be expanded.

**Meeting people’s individual needs**

The service had taken limited steps to support patients with complex needs and those in vulnerable circumstances.

The service had taken limited steps to accommodate the needs of patients with a learning disability and patients with other cognitive impairment, such as patients living with dementia.
Staff told us they would be alerted to those patients who may require additional support by the use of a sticker applied to paper records and a yellow star on the electronic booking system. However, there were limited tools available to support patients with cognitive impairment. There was a limited understanding of the needs of patients with dementia and little evidence of a strategy or use of tools to support this patient group. Staff had access to communication aids such as booklets to aid communication needs with this patient group, but when asked, they found it difficult to locate these. There was a specific feedback form designed to capture feedback from patients with learning disabilities, although some of the terminology used was not appropriate. For example, there was reference to “reasonable adjustments”, a term which may not be understood. There was a hospital-wide learning disabilities group, but the emergency department was not represented on this group.

Some staff, including reception staff, had completed awareness training to help them support people living with dementia. However, there were limited resources available to support this patient group. Staff told us they could obtain twiddle muffs from a ward if needed. Twiddle muffs are knitted items which help to distract patients living with dementia. The department had not identified a dementia champion who could guide and support staff in this area. The frailty team was an excellent source of advice and support, but their availability was currently limited.

The service responded well to the needs of patients with mental illness. There was a responsive mental health liaison service available from 8am to 8pm. There was a frequent attenders meeting held with representatives from the local mental health trust and care plans had been developed.

There were arrangements to support patients whose first language was not English. Staff told us they could access interpreter and translated information.

**Emergency Department Survey 2016**

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

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

**Access and flow**

**People could not always access care and treatment at the right time and in the right setting.** The trust was not meeting national standards in respect of waiting times in the emergency department. Some patients experienced long delays and did not receive care and treatment in the right setting. At times of high demand for services in the hospital, patients were sometimes accommodated in the emergency department overnight.

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

The Royal College of Emergency Medicine recommends that the time patients should wait from
time of arrival to receiving treatment should be no more than one hour. The trust met the standard for all months over the 12-month period from December 2017 to November 2018 and performed better than the England average. During this time, performance against this standard showed a trend of decline and worsened from 12 minutes in January 2018 to 35 minutes in November 2018.

**Median time from arrival to treatment from December 2017 to November 2018 at Weston Area Health NHS Trust**

![Graph showing median time from arrival to treatment](image)

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

There were standards agreed for the review of ED patients by relevant specialty doctors. There was guidance to staff on when to escalate delays and to whom.

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

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From January 2018 to December 2018 the trust failed to meet the standard and performed worse than the England average, except in June 2018. Performance fluctuated around the England average but declined over the winter months.

**Four-hour target performance - Weston Area Health NHS Trust**

![Graph showing four-hour target performance](image)

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

**Percentage of patients waiting more than four hours from the decision to admit until being admitted**
The trust did not report on this metric until October 2018. Performance for October and November was more than 10% worse than the England average.

**Percentage of patients waiting more than four hours from the decision to admit until being admitted - Weston Area Health NHS Trust**

![Graph showing percentage of patients waiting more than four hours from the decision to admit until being admitted.]

(Source: NHS England - A&E SitReps)

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

Over the 12 months from January 2018 to December 2018, 33 patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in January 2018 (15), December 2018 (14) and February 2018 (4).

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

During the winter months a number of patients remained in the emergency department overnight, waiting for a bed. Two incidents had been reported where staff were not able to transfer these patients to a bed, therefore they remained on trollies overnight.

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

This metric is an indication of patient dissatisfaction with waiting times. From December 2017 to November 2018 the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was better than the England average. From May to November 2018 the reported percentage of patients leaving has was 0%. This was most probably a data reporting error. Data provided by the trust during our inspection showed that the percentage of patients who left before being seen in January and February 2019 was between 1% and 3%.

**Percentage of patient that left the trust’s urgent and emergency care services without being seen - Weston Area Health NHS Trust**

![Graph showing percentage of patients that left the trust’s urgent and emergency care services without being seen.]

(Source: NHS England - A&E Waiting times)
Median total time in the emergency department (all patients)

From January 2018 to December 2018 the trust’s monthly median total time in the emergency department for all patients was slightly longer but overall, similar to the England average.

Over this period the trust saw worsening performance compared to the England average over winter periods.

Median total time in A&E per patient - Weston Area Health NHS Trust

The service had taken steps to provide alternative pathways for patients who required urgent care but did not need to be seen in the emergency department. There was a nurse-led primary care service where patients could be referred by staff in the emergency department. This service was run by a third-party organisation and the trust was planning to end the contract as the service was not felt to be effective.

There was a co-located ambulatory emergency care department, which operated Monday to Friday. Patients who were independently mobile, who required investigations or treatment but were not expected to require hospital admission were referred here by emergency department staff or by their GPs. The department operated Monday to Friday only from 9am to 7pm.
Learning from complaints and concerns

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

There was a poster in the emergency department waiting room which advised patients and visitors what to do if they had concerns or wished to make a complaint. We were not able to find any complaints leaflets in the emergency department but when we asked at reception, we were given one. This directed people to speak with a member of staff or contact the hospital’s patient advice and liaison service (PALS). We did see feedback cards and post boxes where people could post their completed cards, throughout the department.

Complaints were managed using the trust’s incident reporting system. All complaints, wherever they arose, were sent to the complaints department, where they were logged and acknowledged. They were then assigned to a staff member for investigation. The complaints department monitored the management of each complaint and sent reminders to ensure that they were investigated in a timely way.

We reviewed three recent complaints about care and treatment in the emergency department. We found they had been appropriately investigated and the complainants had received sensitively-worded and thorough responses, which included an apology and an explanation of any remedial actions taken. We did not see any evidence that complaints were discussed at governance meetings.

Summary of complaints

From December 2017 to November 2018 there were 37 complaints about urgent and emergency care services. The trust took an average of 35 working days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be closed within 40 working days.

A breakdown of complaints by theme is shown in the table below:

<table>
<thead>
<tr>
<th>Subject of complaint</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>13</td>
</tr>
<tr>
<td>All aspects of clinical treatment</td>
<td>9</td>
</tr>
<tr>
<td>Admission, discharge and transfer arrangements</td>
<td>4</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>3</td>
</tr>
<tr>
<td>Communication/information to patients (written and oral)</td>
<td>3</td>
</tr>
<tr>
<td>Attitude of staff</td>
<td>2</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>1</td>
</tr>
<tr>
<td>Communication/information to patients</td>
<td>1</td>
</tr>
<tr>
<td>Medication</td>
<td>1</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)
Number of compliments made to the trust

From December 2017 to November 2018 there were 199 compliments in urgent and emergency care.

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

Is the service well-led?

Leadership

Managers did not always demonstrate they had the right skills and abilities to run a service providing high-quality sustainable care.

The leadership team lacked stability and cohesiveness; there had been many changes in the leadership team over a number of years and some further changes were due to take place in April 2019.

The emergency department sat in the emergency care directorate and was led by a clinical lead (an ED consultant), matron (front door), a senior sister and a seconded operational services manager. The leadership team had undergone numerous changes and lacked stability. They did not meet regularly on a formal basis, although they told us they had plans to do so.

The operational services manager was about to reach the end of their secondment and they were not continuing in the role. They were to be replaced by a recently recruited specialty manager from 1 April 2019. They reported to the general manager for the emergency directorate.

The matron, who was responsible for the ED, the ambulatory emergency care unit, medical admissions unit, medical day care unit and the frailty service, was a fairly recent appointment, following a vacancy of nearly two years, and was on a fixed term appointment, to end shortly. The trust was advertising for a substantive replacement. The matron reported to the associate director of nursing, and they were supported by a senior sister for ED.

The clinical lead reported to the associate medical director and told us they were well supported by them and the trust’s medical director. They also had a mentor, a consultant from a neighbouring trust who had been providing support for approximately six to nine months. The clinical lead was directly responsible for the medical workforce and the oversight of medical rotas. There was a weekly consultants’ meeting. Some consultants had assumed delegated responsibility for areas of responsibility, such as training and audit. The clinical lead had dealt with some difficult issues regarding the medical workforce and had sought support from the associate medical director and the medical director. However, there remained a number of performance issues, for which there was insufficient evidence to demonstrate they had been handled effectively.

Many staff told us they felt supported by the senior sister, the clinical lead, and the matron, who they described as visible, accessible and supportive. The senior sister and the matron helped on the shop floor when the department was busy. However, they told us more senior managers were infrequent visitors to the department and were not felt to be either visible or supportive.

The leadership team told us they met frequently on an informal basis but there was no fixed or formal triumvirate meeting, although this was planned. However, they all attended the weekly ED metrics meeting, also attended by the medical director and director of nursing, where there was a high-level discussion about performance and quality. They were all members of the ED governance committee, although their attendance was generally poor.
The leadership team told us they felt well supported by the executive directors of the trust, but some described unpleasant and difficult working relationships with their direct line managers. (See culture below)

**Vision and strategy**

**The service did not have a formal vision for what it wanted to achieve.** The service was in a state of flux. The future and shape of the emergency department and other ‘front door’ services were currently under review by the local clinical commissioning group and this was currently subject to public consultation.

Staff felt uncertain about their future. There had been numerous communications and opportunities for staff to have their say but few had participated in this and they did not feel well informed.

Operational high-level objectives for the directorate had been defined. There was a draft operating plan for 2018/19, outlining objectives and milestones.

**Culture**

We did not observe a positive culture in the emergency department that supported staff.

**Senior managers had not taken appropriate action to deal with behaviour, which was not consistent with the values of the organisation.**

Some staff told us they did not feel supported, respected or valued. Whilst we saw good teamworking in the emergency department during our visit, some junior medical staff reported concerns about a lack of support from senior doctors. Some staff told us they reported concerns but did not receive feedback. Others told us they were reluctant to report concerns because they were not confident they would be dealt with sensitively or in confidence.

We heard of a number of incidents that had been reported in November and December 2018 that involved alleged bullying and unsupportive behaviours. Support was provided at a local level by some senior staff, but staff reported a perception that this behaviour was not managed.

During our inspection we observed a senior nurse reprimand a more junior nurse for a record-keeping omission. Their manner and tone were unnecessarily aggressive and this took place in full view of us and other staff and patients. Staff told us this sort of behaviour was not uncommon.

A concerning number of senior staff talked about a “toxic culture”. Behaviour was described as aggressive, undermining, rude and disrespectful. Some staff told us they had no confidence in the Freedom to Speak up system.

We brought these, and other reports to the attention of the executive leadership team who immediately commissioned an investigation into these reports.

**Governance**

**The service did not have effective governance systems to provide assurance of quality and safety.**

There was a weekly ED metrics meeting where high-level performance was reviewed against key performance indicators. This fed into a monthly emergency department governance meeting, where, we were told by senior managers, detailed discussion took place about quality and safety matters. There was a standing agenda, which included review of the risk register, health and safety matters, patient safety alerts, incidents, policies and guidelines, safety performance,
training, staffing, audit, complaints and patient feedback, safeguarding, mortality and morbidity and infection control.

Attendance was poor; in November and December 2018 and January 2019 neither the clinical lead nor the front door matron attended the meeting and the senior sister for ED attended for only part of the meeting in November. There was no consultant representative in attendance at the meetings in November and December. In December it was noted that the meeting was not quorate. Minutes were produced but these were brief so they were not a useful source of information for staff who were not able to attend the meeting, nor did they provide evidence of discussion of risk. There was no tracking system to ensure actions arising from the meeting were followed up at subsequent meetings. For example, at the meeting held in November 2018 it was noted that there was a poor response rate to the friends and family survey. It was noted that patients did not notice the terminals at the entrance to the department, which were provided for patients to leave their feedback. It was suggested that a sign should be placed to direct patients to these terminals but nobody was assigned this as an action. At the meeting in December, it was again noted that there was a poor response rate. A junior doctor representative was asked to highlight the importance of the friends and family test to their colleagues. At the next meeting in January 2019, this was not followed up but there was again a discussion about signage to highlight the terminals and the senior sister was given responsibility to progress this. There was no information shared at any of the three meetings about the feedback that had been received.

Audit was not used to drive service improvement. Results from national audits were not formally discussed. The medical director wanted to assure us that the emergency department engaged in clinical audit but sent us incorrect information concerning the national audits which the trust participated in 2017/18. These results had not been discussed or acted upon internally, nor reported to the trust’s clinical effectiveness committee so that the board was assured.

Management of risk, issues and performance

The trust did not have effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and the unexpected.

The emergency department maintained a risk register; however, this was not used to maintain oversight and manage risks effectively. The governance committee was the main forum for monitoring and managing risk, however, this was not well led. Managers told us the risk register was discussed and reviewed at ED governance meetings; however, there was no evidence of review in the minutes of the meetings held in November and December 2018 or January 2019. In November it was noted that the senior sister for ED would update the register with newly identified risks. In December the top five highest risks were listed. These were: ED closure at night and handover, the high number of locums, nurse vacancies, national safety standards not embedded, and sepsis patients not getting timely antibiotics. There was an action recorded for the junior doctor representative to highlight the risk relating to safety standards to junior doctors at handover. In January 2019 there was again reference to a project underway to update the risk register and training dates were publicised. There was no reference to any current risks or mitigating actions.

There had been 12 serious incidents reported in the last 12 months but we saw no discussion about these, including any learning from them at governance meetings. There was no established system for learning from deaths and unexpected outcomes in the emergency department.

Information management
The service collected and analysed information using secure electronic systems but did not use it well to support all its activities.

The service had access to different streams of information but it did not provide leaders with a holistic view of performance. We were not assured that information was used effectively to manage risks to performance and safety.

There was a weekly ED metrics meeting, which monitored daily weekly and monthly operational performance against key performance measures. The medical director told us the focus of these meetings was to measure quality but we found they were more focussed on operational performance. There was no information discussed about patient experience. Performance was RAG rated to highlight areas of risk and to track improvement or deterioration in performance. However, there appeared to be little connection to matters discussed at governance meetings and it was not clear how these information streams informed the risk register.

We did not see any performance data in relation to information governance but during our inspection we observed that staff were alert to their responsibility to protect personal data. There had been one breach of confidentiality reported as an incident in the last 12 months, where a patient was given a prescription with another patient’s details on it. It was not clear what action had been taken to avoid a similar breach in the future.

Engagement

The service did not engage well with patients, staff and the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

Staff engagement

Staff told us there was good day to day communication in the emergency department. There were few opportunities for staff meetings but information was shared briefly at staff handover meetings. The senior sister led most nurse handover meetings. There was a closed social media platform used to communicate news and important information, alongside emails and posters displayed in the staff room. Staff were invited to attend ED metrics meetings and governance meetings, although attendance was not always possible due to capacity. There were weekly consultants’ meetings and the clinical lead met monthly with a junior doctor representative.

Staff were aware of the public consultation exercise in relation to the future and shape of services at Weston General Hospital but few had participated in any formal engagement to express their views. There was a general feeling expressed that the process was not meaningful and their views were not important and would not make a difference.

Public engagement

The trust had engaged with the public and partner organisations about the future of services, and this was ongoing. At a department level, we saw little evidence of meaningful engagement of people who used the emergency department. The service used a variety of methods to capture patient feedback, including paper-based questionnaires and computer terminals at the entrance to the emergency department. The service acknowledged that, like many emergency departments, their response rate was low. There were discussions recorded about steps the department could take to improve this.

We saw little evidence that the service had used patient feedback to drive improvement. There was a ‘You said, we did’ message displayed on a noticeboard in the emergency department, which reported that the department had improved communication in response to patient
feedback, but it did not explain what steps it had taken to improve this. We asked two members of staff about this and they were unable to explain what steps the service had taken to improve communication and told us this was a constant theme arising from patient feedback.

There were positive and collaborative relationships with the local ambulance service. The two services had worked jointly to ensure there was shared understanding of the limitations of the service at Weston General Hospital. On a day to day basis, we saw positive relationships between ambulance and emergency department staff.

**Learning, continuous improvement and innovation**

The service was committed to improving services and we saw improvements in some areas, for example operational performance, record-keeping and management of sepsis, since our last inspection. However, we saw limited evidence of learning when things went wrong, promoting training, research and innovation.

The emergency department had been reconfigured and refurbished since our last inspection, providing a clean, bright environment, which was well laid out and where staff could work safely. Staff talked positively about the larger space for the ‘see and treat’ service to operate in.

Operational performance against national standards was improving but the trust was still consistently failing to meet national waiting time standards.

The identification and management of sepsis had significantly improved. Record keeping had also improved with the introduction of safety sisters.

The emergency department remained closed overnight due to a shortage of staff. The service had recruited more senior medical staff, although they were still not fully staffed. Junior doctors were better supported, although some still voiced concerns about some of their senior colleagues and their lack of proactive support and engagement. This had not been managed effectively. Nursing staff recruitment and retention remained a significant challenge and there was heavy reliance on bank and agency staff. There were still not enough staff who were trained and competent to care for sick and injured children. There was little evidence of learning from incidents and audits.

**Medical care (including older people’s care)**

**Facts and data about this service**

The medical care services at the trust provides the following specialities: medical assessment unit, medical short stay, general and speciality wards such as cardiology, endocrinology, respiratory, stroke, medical gastroenterology, rehabilitation and includes care of the elderly.

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

The medical care service had changed the ward areas since our last inspection in 2017.

A breakdown of medical care wards/areas at the trust is below as seen at the time of our visit in 2019:

<table>
<thead>
<tr>
<th>Ward/Area</th>
<th>Type of service</th>
<th>Number of beds/trolleys</th>
</tr>
</thead>
<tbody>
<tr>
<td>Berrow Ward</td>
<td>Respiratory ward</td>
<td>28 beds</td>
</tr>
<tr>
<td>Cheddar Ward</td>
<td>General medical ward</td>
<td>26 beds</td>
</tr>
<tr>
<td>Endoscopy</td>
<td>Endoscopy – flex-sigmoidoscopy, colonoscopy, endoscopy, oesophageal stent, bronchoscopy, oesophago-gastroduodenoscopy (OGD)</td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>--------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Harptree Unit</td>
<td>Cardiology</td>
<td>27 beds</td>
</tr>
<tr>
<td>Intermediate discharge service (IDS)</td>
<td>Facilitation of discharge including complex discharges with links</td>
<td>N/A</td>
</tr>
<tr>
<td>Kewstoke Ward</td>
<td>Care of the elderly ward – a dementia friendly ward</td>
<td>28 beds</td>
</tr>
<tr>
<td>Medical Assessment Unit</td>
<td>Short stay medical assessment and GP expected patients</td>
<td>14 beds</td>
</tr>
<tr>
<td>Sandford Ward</td>
<td>Medical assessment and gastroenterology</td>
<td>28 beds</td>
</tr>
<tr>
<td>Draycott</td>
<td>Used as winter pressures ward</td>
<td>25 beds</td>
</tr>
<tr>
<td>Therapies</td>
<td>Assistance for patients that require certain therapy assistance such as occupational therapy, dietetics, speech and language</td>
<td>N/A</td>
</tr>
<tr>
<td>Uphill Ward</td>
<td>Stroke unit</td>
<td>24 beds</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>215 beds</strong></td>
</tr>
</tbody>
</table>

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

The trust had 17,865 medical admissions from October 2017 to September 2018. Emergency admissions accounted for 10,282 (58%), 351 (2%) were elective, and the remaining 7,232 (40%) were day case admissions.

Admissions for the top three medical specialties were:

- General medicine – 11,048
- Clinical haematology – 2,100
- Gastroenterology – 1,708

(Source: Hospital Episode Statistics)

On our previous inspection in March 2017 we rated the medical service as requires improvement in all domains except for caring, which was rated good.

During our inspection we spent time on all wards and units across the medical care service. We spoke with 41 staff which included registered nurses, nursing assistants, managers, domestic staff, porters, pharmacists and doctors.

We reviewed 20 care records and obtained feedback by talking with seven patients and their relatives. We reviewed information and data provided by the trust.

Is the service safe?
Mandatory training

The service provided mandatory training in key skills to all staff but not everyone had completed it.

The trust set a target of 90% for completion of mandatory training. Overall compliance with the target was similar to compliance at our previous inspection in March 2017.

A breakdown of compliance for mandatory training courses as of November 2018 at trust level for registered nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Staff eligible</th>
<th>Staff completed</th>
<th>Completion rate</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREVENT</td>
<td>116</td>
<td>111</td>
<td>95.7%</td>
<td>Yes</td>
</tr>
<tr>
<td>MUST</td>
<td>104</td>
<td>96</td>
<td>92.3%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>116</td>
<td>107</td>
<td>92.2%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>116</td>
<td>107</td>
<td>92.2%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>116</td>
<td>107</td>
<td>92.2%</td>
<td>Yes</td>
</tr>
<tr>
<td>Falls Prevention</td>
<td>116</td>
<td>106</td>
<td>91.4%</td>
<td>Yes</td>
</tr>
<tr>
<td>Counter Fraud Awareness</td>
<td>118</td>
<td>103</td>
<td>87.3%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>116</td>
<td>101</td>
<td>87.1%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>140</td>
<td>118</td>
<td>84.3%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>100</td>
<td>83</td>
<td>83.0%</td>
<td>No</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>116</td>
<td>95</td>
<td>81.9%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia Awareness (inc. Privacy &amp; Dignity standards)</td>
<td>116</td>
<td>94</td>
<td>81.0%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>116</td>
<td>93</td>
<td>80.2%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>115</td>
<td>92</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>62</td>
<td>48</td>
<td>77.4%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>116</td>
<td>87</td>
<td>75.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine the 90% target was met for six of the 16 mandatory training modules for which registered nursing staff were eligible. Conflict resolution had the lowest completion rate with 75% of qualified nursing staff having completed this training. Ward managers we spoke with were aware of mandatory training compliance within their areas and were closely monitoring this. They knew who was due to complete mandatory modules and encouraged staff to attend. Staff confirmed training was discussed at appraisal meetings.

Therapy staff had achieved over 90% compliance with mandatory training compliance in all
subjects except adult basic life support. Staff compliance level for this subject was 85%.

The trust provided us with information about mandatory training compliance for medical staff in the medical service which was split into specialist areas. Two specialities did not meet the trust target of 90% compliance with mandatory training. Compliance for medical staff was as follows:

- 84% in ambulatory care, which included locum staff.
- 59% general medical services.
- 100% for cardiology.
- 93% for care of the elderly.

We raised the lack of compliance for medical staff with the leads of the service. Service leads told us many of the medical staff were employed by this trust and a neighbouring trust. In these cases, the main employment was with the neighbouring trust who had the up to date figures for training compliance. We were told they had asked their neighbouring trust for compliance rates, but electronic systems did not allow access by Weston Area Health NHS Trust. Medical leadership was liaising with the neighbouring trust but this was work in progress and not yet resolved.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Training was provided for staff on how to recognise and report abuse and they knew how to apply it but not all staff had completed it.

**Safeguarding training completion rates**

The trust set a target of 90% for completion of safeguarding training. Nursing staff had achieved close to the target. We saw methods ward managers used to monitor compliance with safeguarding training.

A breakdown of compliance for safeguarding training courses as of November 2018 for registered nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Staff eligible</th>
<th>Staff completed</th>
<th>Completion rate</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>116</td>
<td>110</td>
<td>94.8%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>110</td>
<td>96</td>
<td>87.3%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>116</td>
<td>101</td>
<td>87.1%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine the 90% target was met for one of the three safeguarding training modules for which registered nursing staff were eligible. The remaining two modules showed compliance was close to the target.

A breakdown of compliance for safeguarding training courses February 2019 for medical staff in medical care is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Staff eligible</th>
<th>Staff completed</th>
<th>Completion rate</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>50</td>
<td>34</td>
<td>68.0%</td>
<td>No</td>
</tr>
</tbody>
</table>
In medical care the 90% target was met for two of the three safeguarding training modules for which medical staff were eligible.

Service leads told us many of the medical staff were employed by this trust and a neighbouring trust. In these cases, the main employment was with the neighbouring trust who had the up to date figures for safeguarding training compliance. Electronic systems did not allow access by Weston Area Health NHS Trust and could not provide assurance of staff compliance with safeguarding training. We were told they were liaising with the neighbouring trust and this was work in progress but not yet resolved.

The safeguarding lead for the trust monitored safeguarding training, referrals and supervision and reported to the trust executive team on a quarterly basis. Learning points were shared with the executive team and with staff using emails and newsletters. All staff we spoke with could describe safeguarding concerns they would report and where to access support if they needed it.

Cleanliness, infection control and hygiene

The service took steps to control infection risks well most of the time. Staff kept equipment and the premises clean. When an infection was confirmed, they used control measures to prevent the spread of infection.

The trust had a programme of cleaning for all areas of the wards and units. We saw cleaning logs signed and dated by staff detailing areas to be cleaned and frequency needed. This included areas which were harder to reach such as high levels and areas behind beds. Following any infection housekeeping staff completed a deep clean of that area to using solutions to decontaminate the area. All areas we visited appeared visibly clean and free from dust.

Equipment such as commodes, were cleaned between use. ‘I am Clean’ labels indicated they had been decontaminated and were ready for use.

Handwashing and decontamination gels were readily available for staff and relatives to use. There were visible instructions at ward entrances which informed visitors to the ward of the importance and methods of hand cleansing. All staff we saw were bare below the elbow and decontaminated their hands between patient contacts. Patients were offered the opportunity to cleanse their hands before and after meal times. Sealed wipes were provided for their use on meal trays.

Matrons monitored general cleanliness of all areas monthly to ensure standards were maintained.

Hand hygiene audits were carried out monthly and results reported to the Matrons and wards. Audits showed good compliance overall from April 2018 to January 2019. Areas being below compliance in one month had improved the following month except for Cheddar ward which was slightly below the 90% compliance target for October, November and December 2018. We saw action plans devised to improve compliance by spot checks from matrons, giving reminders to staff and making sure audit results were displayed on wards. All areas we visited displayed results of these internal audits.

Side rooms were available on each area we visited which could be used to care for patients whose immune system made them vulnerable to infection or for patients who had an infection. Signs giving instructions for staff and visitors were placed outside rooms. We saw these being
used for patients with infections such as the flu virus. This protected other patients on the ward from the infection.

The trust had improved their infection control facilities by installing doors to segregate six-bedded bays from the remainder of the ward areas. If there were outbreaks of infection such as ‘flu or norovirus, patients could be nursed in these areas without posing a cross infection risk to others.

We saw staff using personal protective equipment such as aprons and gloves when carrying out procedures for patients. The endoscopy service used enhanced protective equipment such as visors and gowns when cleaning contaminated equipment.

The service monitored infections and staff compliance with procedures to ensure infections were kept to the lowest possible risk.

Most patients were screened for infections such as MRSA on their admission to the hospital. This was documented in the notes and patients were nursed in side rooms if they were at risk of the infection until results showed they were clear.

Compliance with screening was audited and reported to the infection control committee. From April 2018 to January 2019, compliance with MRSA screening was above 95% for seven out of 10 months. April, July and October 2018 had results of 90% and 92.5% compliance with screening. This was for whole directorate including emergency department.

Infection rates were monitored by the service and reported to directorate governance meetings.

Incidence of infections from April 2018 to January 2019 were:

<table>
<thead>
<tr>
<th>Incidence</th>
<th>Trust threshold per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA</td>
<td>1</td>
</tr>
<tr>
<td>Clostridium difficile</td>
<td>7</td>
</tr>
<tr>
<td>MSSA (blood stream infection)</td>
<td>8</td>
</tr>
</tbody>
</table>

Managers and specialist nurses discussed the results at governance meetings and decided on actions needed to reduce infections within the directorate. Staff were reminded of actions that would prevent infections such as good hand hygiene. The lead for sepsis and the deteriorating patient was providing training and awareness raising sepsis management around the hospital.

The endoscopy department followed health technical memorandum 01-06 for management and decontamination of flexible endoscopes. We saw a one-way system for clean and dirty items which ensured there was no cross contamination. Clean equipment was removed from drying cabinets and had green covers. Contaminated equipment was placed in trays with red covers. The department used a system which could track equipment and patients it had been used for, should there be any concerns or failure of equipment. Quarterly audits of decontamination processes for the endoscopy area were produced which provided assurance of systems to prevent infection risks. Water microbiological checks of final rinse water of the endoscopes was checked as having taken place weekly. Actions were identified if results were unsatisfactory. Some results for October and November 2018 were unsatisfactory. This meant potential problems were investigated and further disinfection of the machines were undertaken to improve decontamination of equipment. Following descaling of equipment, the December 2018 showed results were within acceptable limits.
Patients who were undergoing endoscopic procedures were screened for infections. Patients with suspected or confirmed diagnosis of infection underwent their procedure at the end of the day. The area had an enhanced level of cleaning before further patients were cared for there.

**Environment and equipment**

**The service had suitable premises and equipment in most areas and looked after them well.**

At our previous inspection in March 2017 we found fire exits on the stroke unit were blocked by chairs and other furniture and equipment. The reason for obstructing the fire exits was given as being due to additional beds being placed on the ward. Since that inspection the stroke unit had moved location and these fire exits were unobstructed. However, on Berrow ward we found one fire exit was partially obstructed by chairs. The extinguisher storage could also present a risk to patient safety. This was because they were not fixed to the wall but were stored on a moveable stand and could be knocked over. The service informed us these issues were corrected at the time of the inspection.

**There were some issues with storage facilities.** Specialist safety equipment was in short supply at the 2017 inspection and purchase of additional equipment was waiting for approval. We found that new equipment had been purchased at the time of our inspection, including six stroke chairs. However, the stroke unit had been moved to a different part of the hospital which was a brighter environment and we found that storage of this equipment was problematic in the new area. The storage room was too small and cluttered. Staff had raised this to management and were waiting for this to be resolved.

**Substances hazardous to health were accessible to patients.** We found one sluice area which had a hazardous substance left on the sink and the door was not locked.

**All equipment we saw was maintained and within their servicing dates.** Staff were clear about the system and actions they took to report any repairs needed. Staff would call the maintenance department and complete a request sheet for repair. Defective equipment was clearly marked as not to be used.

**All areas we visited had resuscitation equipment available which was ready to use if needed.** These had been checked daily as working properly and had numbered tamper evident closures. Each week a detailed check of the equipment was performed and new tamper evident tag was attached to the equipment. The numbers we checked corresponded accurately with the checking log.

**Management or waste and specimens kept patients and staff safe.** Waste was segregated into appropriate bags and locations and collected for disposal by portering staff. The oncology and haematology unit had appropriate disposal methods for cytotoxic waste. Staff used a chute system which connected to the hospital laboratories.

**Equipment for patient safety was available for use.** Pressure sensor mats, hi-low adjustable beds, coloured socks to identify patients at high risk of falls was used for patients who needed it. Kewstoke ward, which cared for elderly and dementia patients, had a managed access system. This was to protect confused patients from wandering off the ward. Staff were able to access the ward using a swipe card and doors were monitored when visitors arrived at the ward.

**Assessing and responding to patient risk**

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
Risk assessments This included their risk of infection, falling, mental health, dementia, venous thromboembolism and pressure ulcers. Once patient risks were identified care plans were developed to advise care and treatment to minimise harm.

**Staff used systems to make sure staff were aware of patient risks and to reduce potential harm.** Patients were referred for further support such as nurse specialists for diabetes, dementia care and mental health support. Risks were highlighted on ward white boards and discussed at safety briefings. Patient bed spaces had ‘at a glance’ boards. These boards had indicators of patient needs such as special diets, risk of falling and dementia. All staff caring for the patient could view the symbols and be aware of the patient needs.

**Staff were aware of how to identify patients who may cause harm to themselves or others.** We saw assessments and management plans used for aggressive patients and how staff monitored moods and activities to protect other patients. We also saw examples of how they had worked with the psychiatry liaison team and a patient’s family to help manage their delirium and underlying mental health issues. This had involved discussion with relatives to identify patient’s usual behaviour and referral was made to mental health services.

**Patients were monitored and assessed using the National Early Warning Score (NEWS).** The trust had been identified as a suitable environment to trial the updated NEWS 2 scoring system. This was a system of monitoring patient’s vital signs, such as temperature, respiration rate, blood pressure and pain. A score was calculated and actions were advised for nursing staff according to the score. Any patient whose condition was deteriorating could be identified and their condition escalated for further medical review. Patient NEWS charts we reviewed were completed and acted upon appropriately.

Any patient presumed or confirmed as suffering with sepsis was cared for using the sepsis six care bundle. Management of sepsis after admission to hospital usually involves three treatments and three tests, known as the "sepsis six". These should be initiated by the medical team within an hour of diagnosis. The sepsis lead in the hospital monitored how well patients with sepsis were cared for and promoted the administration of antibiotics within an hour of diagnosis. We saw certificates awarded to wards confirming this had taken place.

**Acutely unwell patients were cared for in beds close to the nursing station. This was a problem in some areas, if a patient needed to be nursed in a side room and it was not easily visible by nursing staff.** We saw a patient who was being cared for in a side room because they had an infection that could spread. However, the patient was receiving treatment that required close monitoring. Guidance for the care of this patient was they should be cared for by a nurse who had a maximum of two patients. They were being cared for by a nurse who was monitoring five other patients and did not have constant sight of this patient. We raised this risk to the nurse in charge and the matron. We were informed the patient had been reviewed by a specialist nurse that morning, was being weaned off ventilation support which was also used at their home and was considered stable. The following day the patient was outside of the infections stage of their illness and was moved to the general bay where they could be observed more easily.

**The lead for patient falls worked with the newly appointed quality and safety lead to reduce the number of falls in the service.** Actions were being taken to raise staff awareness of falls, potential increased length of stay in hospital for the patient and actions nursing staff could take to prevent falls. Display boards were being used to demonstrate the learning in highly visible areas for staff to view. Staff were advised to complete a SWARM. This is an immediate
investigation of the event to identify actions that could be put into place quickly to prevent further patient falls.

The endoscopy service used the WHO (World Health Organisation) surgical safety checklist for patients attending their unit. This is a set of checks staff should document before any surgical procedure to prevent error. Completion of the checklist supported patient safety ensuring that details were checked by all staff in the procedure room. Audits of WHO checklists showed 100% compliance for October 2019.

Patients attending for endoscopy were assessed and seen if they were clinically stable. Should a patient become clinically unwell medical staff would review them and admit to the hospital if it was needed.

The service had implemented Local Safety Standards for Invasive Procedures and had a system of reviewing further areas for development. These were safety standards which were based on national safety standards and learning from serious incidents and near misses. They could be adapted for local use and were used for all invasive procedures. These were presented to the clinical effectiveness group for review and comment before being cascaded for staff use.

We observed safety huddles taking place on wards. These were short multidisciplinary briefings held on ward areas. The aim was to promote understanding of each patients’ condition and anticipate future risks to improve patient safety. Risks of falling, nutrition, pressure ulcers and mental health formed part of the discussions.

Patient records we reviewed showed that patient assessments met London Quality Standards which meant that patients were seen by relevant consultants within 12 hours of admission. Patients conditions were monitored and any patients whose condition became unstable or was deteriorating was reviewed by a consultant at any time during the week and at weekends. Out of normal working hours an on-call consultant would review new admissions each morning. Medical staff we spoke with felt supported by consultants in the medical care service and were comfortable to seek advice when needed. A critical care outreach team were available to support acutely unwell patients and there was access to on-site level two and three critical care.

There were times that medical patients had to be cared for on wards that were not a medical specialty. Patients were nursed as outliers and came under the responsibility of medical care doctors. These patients were assessed for suitability of being cared for on other wards and any medically unwell or unstable patients were cared for on medical wards and not as outliers. These patients were reviewed by medical staff from the medical care service.

Staff could access specialist support including mental health, learning disability, dementia leads and mental health liaison team. They used screening questions to help identify patients with depression or low mood and refer them to the liaison team for assessment.

The sepsis lead and quality improvement team were working on a programme to improve identification and treatment of neutropenic patients (patients with a low level of white blood cells) who were at risk of developing serious infections.

Staff were supported by a palliative care team who visited wards regularly. They had close working relationships and were able to support staff, patients and relatives when patients were reaching the end stage of their life.

Nurse staffing
The service did not have enough nursing and therapy staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. Gaps in planned staffing levels could not always be filled by agency or bank staff.

The trust reported their nurse staffing numbers by ward below for March 2018 and November 2018 for medical care. Overall fill rate had decreased by 9%. The biggest changes over the two months were at Uphill ward, Sandford ward, and intermediate discharge service.

Additionally, the intermediate discharge service and endoscopy showed positive nurse staffing fill rates. In comparison, there was low nursing staff fill rates reported in uphill ward with only one whole time equivalent (WTE) staff member reported against the 14 planned staff. There had been a change in the ward specialties after this reporting period. Uphill, which had been a rehabilitation and stroke unit, was allocated as the winter pressures ward and was not opened until later in the year. Nurse staffing of this ward was provided from other medical wards in the hospital who worked on Uphill as a temporary measure along with bank and agency staff.

<table>
<thead>
<tr>
<th>Ward</th>
<th>March 2018</th>
<th>November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward</td>
<td>WTE Planned</td>
<td>WTE actual</td>
</tr>
<tr>
<td>Ambulatory Emergency Care</td>
<td>2.9</td>
<td>1.6</td>
</tr>
<tr>
<td>Berrow Ward</td>
<td>21.8</td>
<td>14.6</td>
</tr>
<tr>
<td>Cheddar Ward</td>
<td>17.0</td>
<td>16.7</td>
</tr>
<tr>
<td>Endoscopy</td>
<td>0.0</td>
<td>13.3</td>
</tr>
<tr>
<td>Harptree Unit</td>
<td>16.6</td>
<td>13.3</td>
</tr>
<tr>
<td>Intermediate discharge service (IDS)</td>
<td>3.6</td>
<td>6.8</td>
</tr>
<tr>
<td>Kewstoke Ward</td>
<td>19.2</td>
<td>12.3</td>
</tr>
<tr>
<td>Medical Assessment Unit</td>
<td>19.2</td>
<td>13.4</td>
</tr>
<tr>
<td>Medical Day Unit &amp; Discharge Lounge</td>
<td>5.4</td>
<td>2.6</td>
</tr>
<tr>
<td>Sandford Ward</td>
<td>21.8</td>
<td>0.0</td>
</tr>
<tr>
<td>Stroke Unit (Draycott)</td>
<td>19.2</td>
<td>10.9</td>
</tr>
<tr>
<td>Uphill Ward</td>
<td>14.0</td>
<td>10.6</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>160.5</strong></td>
<td><strong>116.1</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Following our inspection visit the service provided us with amended data regarding fill rates:

<table>
<thead>
<tr>
<th>Ward</th>
<th>March 2018</th>
<th>November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward</td>
<td>WTE Planned</td>
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</tr>
<tr>
<td>Endoscopy</td>
<td>0.0</td>
<td>13.3</td>
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<td>Uphill Ward</td>
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</tr>
<tr>
<td>Ward</td>
<td>WTE Planned</td>
<td>WTE actual</td>
</tr>
<tr>
<td>--------------------------</td>
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</tr>
<tr>
<td>Ambulatory Emergency Care</td>
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<td>1.6</td>
</tr>
<tr>
<td>Berrow Ward</td>
<td>24.4</td>
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</tr>
<tr>
<td>Cheddar Ward</td>
<td>17.0</td>
<td>10.7</td>
</tr>
<tr>
<td>Endoscopy</td>
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<td>6.7</td>
</tr>
<tr>
<td>Harptree Unit</td>
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<td>13.3</td>
</tr>
<tr>
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</tr>
<tr>
<td>Kewstoke Ward</td>
<td>19.2</td>
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</tr>
<tr>
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<td>13.4</td>
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<tr>
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<td>2.5</td>
<td>2.2</td>
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<tr>
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<td>21.8</td>
<td>10.9</td>
</tr>
<tr>
<td>Stroke Unit (Draycott)</td>
<td>19.2</td>
<td>10.9</td>
</tr>
<tr>
<td>Uphill Ward</td>
<td>14.0</td>
<td>9.6</td>
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<tr>
<td><strong>Grand Total</strong></td>
<td><strong>169.4</strong></td>
<td><strong>110.5</strong></td>
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The amended data showed the overall fill rate had remained much the same (increase by 0.8%).

**Staffing reviews were held six-monthly to determine the level of nursing staff needed for the acuity of patients being cared for in the service.** The analysis was based on nationally recommended guidelines. The safer staffing review, which was based on staffing up until April 2018, identified a range of actions for the trust to improve staffing levels. This included strategies of recruitment and retention. Increases in staffing levels were identified for Berrow and Cheddar wards and skill mix changes were identified for Harptree ward. The trust was offering financial incentives to attract staff and were engaging in international recruitment programmes. This was a work in progress and posts were being advertised. An acuity tool had been trialled at the trust to determine the number of staff needed to care for the level of patient need on the ward. This had been implemented in the medical care division during the week of our inspection and staff were adjusting to the new process.

At our inspection of 2017 staff had commented on limited access to ward clerks which put additional pressures on nursing staff to complete administrative tasks. The service had recruited additional ward clerks. The increase in the number of ward clerks on wards freed up nursing staff to respond to nursing care needs of patients.

**Occupational therapists and physiotherapists worked in teams to support patient care, treatment and rehabilitation although staff levels could not meet demand.** A team of therapy staff were allocated to work with stroke patients and were based on the stroke unit. Another team were allocated to medical care and elderly care patients. Staff felt there were pressures on their
time due to staff vacancies and long-term leave within the service. Locum staff were available and were used every day to cover the workload. The allocation was planned to be one physiotherapist at band five level per ward. However, we were told they would cover four wards each at times of short staff. A band eight provided leadership for both physiotherapists and occupational therapists.

Between the dates reported above some changes had been made to the ward areas and types of patients they treated. Uphill ward had changed to become the stroke unit. Draycott had been reallocated as the winter pressures ward and had opened in the autumn of 2018. This was staffed using staff from around the medical care and bank and agency nursing staff. The plan was that this ward would close at the end of March 2019 and staff would return to their substantive roles on their original wards. This arrangement put additional pressures on staffing needs of the medical care wards.

Gaps in rotas were filled by bank and agency nursing staff. Where a patient needed enhanced care, because of additional risks such as falling or their condition needing increased nursing observation and support, bank nurses were requested. However, they were not always available when requested. Nursing staff were unable to provide care for patients in a way that was recommended for their condition. One patient we saw should have been cared for on a one to two basis (one nurse to two patients). However, there were not enough trained nurses to provide this level of care and they were caring for a bay of six patients in addition.

**Vacancy rates**

The nursing workforce had vacancies in its agreed levels for each ward.

From December 2017 to November 2018, the trust reported a vacancy rate of 31% in medical care. This is higher than the trust target of 8% and the trust average of 15.7%.

Sandford ward had the highest vacancy rate (41.5%) followed by Berrow ward (39.3%) and the stroke unit (Draycott) (35.3%).

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

**Turnover rates**

Numbers of nursing staff leaving the service as a whole were lower than other areas in the hospital. However, staffing in the stroke unit and Berrow ward was unstable with more staff leaving their roles.

From December 2017 to November 2018, the trust reported a turnover rate of 12% in medical care. This is lower than the trust target of 15% and the trust average of 17.9%.

The units with the highest turnover rates are Stroke unit with 45.4%, Berrow ward with 23.9% and the medical assessment unit with 10.5%.

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

The medical care leadership team were aware of the high vacancy and turnover rates and were working with trust executive team to recruit and retain staff. There were challenges to recruiting new staff to a small trust and many staff we spoke with had worked at the hospital for a number of years. We also heard of newly recruited staff who expressed their intention to move away from the trust. This included staff who were on fixed term contracts.

**Sickness rates**

From December 2017 to November 2018, the trust reported a sickness rate of 5% in medicine. This is higher than the trust target of 3.9% but lower than the trust average of 17.9%.
The units with the highest sickness were Kewstoke ward (8.9%), medical assessment unit (8.1%) and Berrow ward (7%).

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

Nurse managers were aware of staff sickness levels and the reasons for them. They were expecting some staff to return from long term episodes of sickness and other staff had experienced genuine short-term illnesses such as viruses.

Bank and agency staff usage

Not all available shifts were filled using bank and agency staff which impacted on the work load of staff working shifts which were short of staff.

From December 2017 to November 2018, the trust reported that 7.6% of qualified nursing shifts in medical care were filled by bank staff and 13.1% of shifts were filled by agency staff. In addition, 2.5% of shifts were not filled by bank and agency staff to cover staff absence.

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

The service was sighted on increasing staff numbers for the agreed establishment for each ward to reduce the use of bank and agency staff. This would reduce the budgetary spend and demand on these staffing groups.

We saw effective nursing handovers and safety briefings between nursing staff. All nursing staff had a safety huddle at the start of the shift which identified risks for all patients on the ward. This included any patients who were sick, at risk of falls, at end of life and those living with dementia. More detailed information was shared for the specific patients who were allocated to nursing staff.

Medical staffing

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

The medical leadership team provided us with information on substantive numbers of medical staff. There were 58 medical staff recruited to permanent positions in the medical care service. Two consultants were recruited on a long-term locum basis and supported the medical staffing rotas.

Vacancy rates

The vacancy rate was high, and the service had experienced difficulty in recruiting to roles. From December 2017 to November 2018, the trust reported a vacancy rate of 53.8% for medical staff in medical care. This was higher than the trust target of 8%.

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

The medical care leadership team were actively recruiting to consultant roles and anticipated a full complement of middle grade medical staff would be in place by August 2019. These posts had been recruited to using international recruitment processes which were in progress and training posts, once they had been allocated by the medical deanery.

Turnover rates

The rate of medical staff leaving the service was low, which was building a stable medical workforce. From December 2017 to November 2018, the trust reported a turnover rate of 0% for medical staff in medical care. This was lower than the trust target of 15%.
Sickness rates

Sickness rates were low for medical staff in this service. From December 2017 to November 2018, the trust reported a sickness rate of 0% for medical staff in medical care. This was lower than the trust target of 3.9%.

Sickness rates were monitored by service leads and reasons were observed. There were no reported long-term sicknesses for staff suffering with stress related issues.

Bank and locum staff usage

There were a high number of shifts filled by using locum medical staff which staff told us could be unsettling. From September 2017 to February 2018, the trust reported 4,597 shifts had been filled by locums. Locum consultants had filled 2,175 of these shifts. We reviewed medical rotas and found that any gaps had been filled by locums and consultants working additional hours.

Staffing skill mix

In September 2018, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the 47 whole time equivalent staff working in medicine at Weston Area Health NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
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<tbody>
<tr>
<td>Consultant</td>
<td>27%</td>
<td>44%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>28%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>40%</td>
<td>20%</td>
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^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty

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

* Junior = Foundation Year 1-2

Junior doctors felt well supported with clinical decision making. The skill mix showed there were more junior doctors and fewer consultant grade medical staff for the service than the England average for other medical care services. This could be a challenge to the amount of support junior doctors received. In 2017, junior doctors felt they did not receive enough senior support when caring for elderly patients. The service had responded and consultant in the care of
the elderly was recruited. All junior with doctors we spoke told us they felt supported by senior clinicians and never had a problem in accessing further advice.

Medical staff took part in multi-disciplinary meetings to discuss patients’ care, treatment and discharge plans. Doctors handed over care of their patients when they changed shifts and consultants ensured they had oversight of patient needs by attending handover meetings.

**Records**

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

Patient records were in paper format and kept in trolleys with number key code locks, when not in use. Authorised staff were able to access the records when they needed to review or add to the records.

We reviewed 20 patient records and found them to be up to date, signed and legible with clear plans of care identified. Ward clerks supported the maintenance of patient records and we found them to be well ordered so that information was easy to find. Specialist nurses added information to the patient record to ensure all staff were aware of advice for specific patient needs.

Nursing care records were kept in folders at the end of each patient bed. This allowed quick access for staff who needed to view any risks, care plans and current patient condition.

Risk assessments were completed for each patient and care plans developed from them. Oversight of patient needs were kept on white boards where staff could view patient needs at a glance. Symbols were used, which staff understood, to denote any patients with additional needs including mental health needs, risk of falling and special diets. We saw risk assessments completed by specialist nurses for respiratory needs of a patient. This had offered advice according to national guidelines and specific needs of the patient.

We were provided with no information of overarching record keeping audits. However, the service monitored aspects of record keeping. The service carried out record keeping audits as part of monthly perfect ward and matrons’ audits. For each area of record keeping such as patients’ risk assessments, ward staff were monitored and results were fed back at team meetings.

**Medicines**

**The service did not always follow best practice when prescribing, giving, recording and storing medicines. Patients did not always receive the right medication at the right dose at the right time.**

**Medicines storage did not always follow best practice guidelines.** Most medical wards stored medicines securely with access restricted to clinical staff. However, we found Berrow treatment room was accessible by non-clinical staff and not all medicines were locked away. Medicines had been left on a bench in the treatment room because they would not fit into patient lockers. Glucagon, a medicine, used for diabetic patients in urgent situations, was not clearly marked with updated expiry dates. This was identified at the inspection in 2017. The medicine has a shelf life of 36 months if kept in the fridge, which reduces to 18 months when removed from the fridge. We found glucagon in a treatment room, outside of a fridge but no date was documented of when it was removed from the fridge. This meant it could have already been past its expiry date.

**Controlled medicines were stored correctly.** These are medicines that have additional securities due to the effects they can have on people’s health. We saw logs of daily stock checks
completed and signatures of two staff when administered to patients. Cupboards were locked and secured to a wall with ordering books locked away.

**There was no assurance all medicines were within their expiry date when used.** We found numerous medicines, which have a reduced shelf life once opened, without the date of opening documented. This included bottles of pain-relieving medicine, nebuliser (respiratory) medicine. We found tablets in medicines trolleys on two wards which were past their expiry date and strips of tablets without their expiry date on the strip. There were loose strips in trolleys where it was not possible to see the medicine name, strength or expiry date.

**Medicines were at risk of being kept at incorrect temperatures if there were extremes of weather temperatures. This could compromise the efficacy of the medicine.** Room temperatures, where medicines were stored, were not monitored. This was identified at the inspection in 2017 and was not in line with trust policy. The policy states the ambient temperature for the storage of medicines should be monitored regularly and should not exceed 25 degrees Celsius. There were no records of room temperature checks to verify rooms stayed within this level.

Patients own medicines, which were stored in their bedside lockers, were stored securely. Keys to access the lockers were held by nursing staff.

Medicines which needed to be kept cooler, were kept in fridges and the fridge temperatures were checked daily with a log made of the temperature levels. If temperatures were outside of stated ranges staff were knowledgeable about how to report it. They described actions they would take to manage the medicines correctly such as transferring medicines to another fridge and seeking pharmacy advice.

**Staff were not assured that patients received medicines which were in the best condition and would be effective.** We saw some medicines, which had been dispensed by other pharmacies for patients, were being re-used instead of returned to the pharmacy for disposal. This was not in line with the trust policy or good practice. There was no assurance of how these medicines had been kept when in the patient’s home and how effective they would be. Staff told us if tablets were in the trolley, they would be used.

**Medicines were ordered appropriately.** Patients who needed medicines ordered for them when they came into hospital had them ordered by nursing staff. The order was checked by a pharmacist against the medicines chart before it was dispensed.

**Patients were at risk of not receiving medicines at the correct time and may miss doses which were prescribed.** We saw that one patient did not have their medicines transferred from MAU to Berrow ward. The patient had moved to Berrow ward on the 25 February and MAU had stored the medicines in a locked cupboard. On the morning of the 26 February, medicines had not been given to the patient because the Dossett box had not been transferred from MAU and the ward had no stock of the medicines.

A discharge lounge was available for patients who were well enough to go home and waiting for transport of medicines. Nursing assistants cared for these patients. Staff went to the medical day care unit for support from a registered nurse but had to wait until a registered nurse was available. We saw patients had their medicines later than the prescribed time.

**The process for supplying medicines for patient discharge in the discharge lounge could cause delays.** This was because there were no trained nurses or pharmacists allocated to the discharge lounge to supply and explain the medicines to the patient. A registered nurse provided this service from another ward area but staff needed to wait for their availability. The pharmacy
department had recognised this as a concern and had submitted a business case to the trust’s executives’ team for a pharmacy technician to provide this service.

Prescription paperwork (FP10s) which were used by medical assessment unit were stored securely with each numbered prescription documented in a log book so it could be tracked.

**Medicines were appropriately prescribed for patients, but prescriptions were not clinically checked by pharmacy staff in a timely way.** Medical staff had access to British National Formularies to support their knowledge and prescribed medicines for patients when they were admitted to the ward. However, prescriptions were not always checked by pharmacy staff in a timely way. When patients are admitted to a ward, pharmacy staff should provide a reconciliation of medicines to avoid medication errors such as omissions, duplications and drug interactions. This checks that they are continuing with medicines they normally take at home and if there are any discrepancies, staff would discuss with the prescribing doctor. We reviewed 11 charts and two had been reconciled by a pharmacist and only four had been clinically screened. Pharmacy staff stated their role was to ensure medicines were ordered for patients and supply of medicines was their priority. We saw an occasion when nursing staff were checking medications ready for a patient’s discharge. At this time, it was found six of the patient’s medicines usually taken at home, had not been prescribed for the duration of their admission. Staff continued to investigate the incident, verify the appropriate medicines the patients should have been taking and amend the discharge prescription.

There was a nurse prescriber on MAU which supported timeliness for patients who needed prescriptions when a doctor was not available. A nurse prescriber undertakes additional training and can prescribe medicines without a doctor being present.

**Medicines were not always administered to patients in line with national guidance.** We saw one patient had been given lactulose without a prescription. This medicine used to be on a list of medicines that could be given without a prescription but had been removed. The staff member was not aware of the change and had given the medicine. Patients were able to administer themselves medicines if they chose to. Patient lockers had lockable compartments to keep the medicines in and nursing staff held the keys. We reviewed 11 medicine charts and found allergies had been stated, venous thromboembolism (clotting) risks were assessed and medicines had been given as prescribed.

To reduce delays when discharging patients, the unit had pre-filled packs of frequently used medicines available. These packs had a label attached with space for patient name and date to be written by nursing staff supporting the patient discharge. We found these were being stored in the same cupboard as medicines which were provided for ward stock. There was a risk that these could get muddled and patients could be provided with medicines to take home which did not have their name, address of hospital and date of dispensing on the pack. This was not in line with national labelling requirements or trust policy.

Staff were knowledgeable about medicines, their use and side effects. Patients rarely needed medicines to manage aggression or agitation (known as rapid tranquilisation). Staff were knowledgeable about potential side effects such as over sedation and knew when to use rescue medicine to reverse the effects of the sedation if needed. There were no prompts to support newer staff with national guidance available for staff to follow on post injection health checks.

**Staff used audit measures to improve practice.** Pharmacy staff shared information with ward staff regarding safety alerts and drug recalls. Medicine incidents and errors were recorded using the trust incident reporting system and learning was shared across the trust. Staff used
newsletters and staff meetings to share information. Pharmacy staff attended ward sisters’ meeting each month to share and listen to concerns.

**Practices regarding appropriate use of antibiotics were monitored by the service.** A pharmacist with responsibilities around antimicrobials, completed a monthly ward round with a microbiologist to review patients who are prescribed antibiotics. They produced ward specific reports on whether indication for antibiotics was documented, appropriateness of prescribing and if it had been reviewed/stopped in a timely manner.

An electronic prescribing system was used for chemotherapy medicines. A consultant prescribed the first dose. Pharmacists were trained to review chemotherapy prescriptions and new pharmacists were undergoing training.

Guidelines on sedation of endoscopy patients were followed by staff. This was informed by national guidance and included giving least sedation needed for the procedure and to maintain patient comfort.

**Incidents**

The service managed patient safety incidents well. Staff mostly recognised incidents and reported them appropriately on most occasions. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff spoke knowledgeably about the electronic incident reporting system. They received feedback about any incidents reported. Incidents were discussed at ward Wednesday meetings and learning was shared at ward meetings, using newsletters and updating staff by email.

**When things went wrong, staff apologised and gave patients honest information and suitable support.** Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation, which was introduced in November 2014. This regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. Staff we spoke with were aware of this legislation and demonstrated good understanding of their responsibilities to their patients under this legislation. Staff at all levels were able to describe what the duty of candour involved, and the actions required, and where to look for guidance on the hospital’s intranet. Investigation templates for the investigation also asked for comment on duty of candour and whether patients and relatives had been informed of the investigation results and actions. Records we reviewed affirmed this had taken place.

**At times staff did not identify incidents that should be reported which meant they may not be raised as issues for improvement.** As an example, we were told of an incident of incorrect medication being given which caused patient harm. This had not been reported as an incident until we raised it with relevant medical staff. Issues of difficulty accessing medical reviews had been reported verbally but not using the formal reporting channels.

**Staff undertook mortality and morbidity reviews to provide information on how to reduce harm to patients.** The service reviewed deaths in line with the national death review guidelines. We saw presentations for staff which included anonymised information about patient journeys through the hospital and reasons why their condition deteriorated. Learning points from the cases presented were shared with staff.

National patient safety alerts were reviewed and cascaded to staff for their information.

**Breakdown of serious incidents reported to STEIS**

In accordance with the serious incident framework 2015, the trust reported 20 serious incidents
We reviewed three serious incident reports and found them to be comprehensive, including identified actions for improvement. The more common incident reports contained prompts for support staff who were investigating. For example, patient falls had specific prompts about their assessment of risk. Pressure ulcer incident reports prompted staff to identify when mobility assessments were carried out. We saw some of these actions had prompted changes in practice and had been discussed at steering groups for falls and ward sisters’ governance meetings. Staff investigated all patient falls. If there was any patient harm, there was an immediate multidisciplinary assessment and analysis of the root cause of the incident.

Safety thermometer

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service. The safety thermometer is widely used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the safety thermometer showed the trust reported 13 new pressure ulcers, seven falls with harm and 10 new urinary tract infections in patients with a catheter from November 2017 to November 2018 for medical services.
The trust was aware of a lack of validation for this information and had put in a process to ensure data was reported correctly. This was after the reporting dates specified in this report.

Wards were open about the results from this data collection and displayed their results on the wards. Matrons discussed the results and identified areas where improvement could be made. One of these areas was in reducing falls. Harptree ward had found a higher number of patient falls than in other areas of the medical care service. Education had been initiated on this ward to reduce the number of falls and was to be rolled out to other wards for staff awareness and action.

Kewstoke operated a ‘tagging’ system for patients who were placed in enhanced observation bay. If a nurse was to leave the bay or go behind a curtain, they ensured another member of staff was available to monitor the patients. There had been a reduction in falls since staff had been using this system. From February to October 2018 patient falls had remained below the median of 7 falls a month which was better than from May 2017 to January 2018 when falls remained above this median.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance. Policies, procedures and pathways were based on best practice guidelines and were accessible on the trust’s intranet. As an example, palliative care nurses had developed pathways of care for staff to follow and would support staff and patients. Staff followed pathways for patients who had sepsis which followed national guidance. An admiral dementia nurse developed pathways for patients and included a delirium pathway to inform staff the best options for care.

The service carried out a programme of local audits to assess the quality standards of care provided. This included catheter care, cannula care, hand hygiene, pressure areas, falls
and cleaning. Audit results were fed up to specialist nurses and matrons for review. Results were fed back to wards and levels below acceptable standards had actions for improvement identified. Any trends were identified and support was offered to staff on the wards to improve results. Sandford had been identified as having a higher number of patient falls than other wards. An education programme was started on this ward to test its effectiveness.

The service contributed to national benchmarking audits and monitored their performance. For example: care of patients in heart failure, chronic kidney disease in adults, diabetes in adults. Action plans were developed where improvements needed to be made and these were reviewed by medical staff at physicians’ weekly cabinet meetings.

The service contributed to the myocardial ischaemia national audit project (MINAP) for 2015 to 2016. The results showed an improvement on the results from the 2013/14 audit for two of three metrics. Percentage of patients seen by a cardiologist was 98% which was better than the England average of 96%, 91.4% of patients received angiography which was better than the England average of 86%. No patients were admitted to a cardiac ward because there was not a cardiac ward in the hospital at the time of the audit.

The service audited records against London quality standards regarding consultant review within 14 hours of arrival at the hospital. For one week in April 2018, 42 out of 107 patients admitted, had no documentation to confirm the review had happened. Most of reviews had not had a time documented and so failed the standard. However, records we reviewed in February 2019 had met this standard. Patients in general ward areas were reviewed daily by a consultant unless a review would not affect the patient’s care pathway.

Sepsis screening and management was in line with UK sepsis trust guidelines. Quality improvement methodology had been used to implement changes and support staff to improve identification and management of sepsis in patients. Awareness and training had been provided, highly visible posters were in hospital corridors and staff were informed of their performance in timeliness of administering antibiotics. Staff compliance with using the inpatient sepsis screening tool had improved from 17% in September 2017 to 92% in May 2018.

Audits showed that patients consistently had their risk of developing venous thromboembolism (VTE) assessed and treated in accordance with National Institute for health and Care Excellence (NICE) guidelines. Trust-wide figures were above 94% for patients having had their risks assessed and records we reviewed all had VTE risks documented.

The service encouraged staff to take part in national initiatives and a lead was identified for each. These were activities which were nationally recommended initiatives of commissioning for quality and innovation (CQIUNs). Two of the CQUINs were regarding the identification and treatment of patients with sepsis and were led by a specialist nurse for sepsis and the deteriorating patient. Audits were completed and junior doctors were involved in contributing to audits for clinical antibiotic review of inpatients with sepsis. Compliance of antibiotic review within 24 to 72 hours for inpatients with sepsis, had improved from 92% in October 2017 to 100% for 4 months from February to May 2018. We reviewed records which confirmed antibiotic reviews were taking place appropriately for these patients.

Patients who may be frail or vulnerable received a comprehensive assessment of their physical, mental and social needs. The frailty service was being developed to provide appropriate care for frail and vulnerable patients. Additional staff had been recruited to the team including, an advanced physiotherapy practitioner, and a pharmacist. They worked closely with the emergency department and the elderly care unit as well as with local services outside of the hospital. The team were auditing their activity and results for January 2019 demonstrated that 16 out of 22
patients who were seen and over the age of 75, were not admitted. This meant their needs were met using more appropriate methods and beds were available for other patients. As an example, patients had received antibiotics, care packages had been adapted to enable patients to have their needs met and avoid unnecessary hospital admission.

Patients in the medical assessment unit had been reviewed by a consultant twice daily and were not able to be transferred to a ward area until the consultant sanctioned the decision.

Staff used regular handovers throughout the day to ensure that all the team on duty were aware of patients’ psychosocial needs, and risks in a timely way. Patients were assessed for risk of violence or aggression and worked with patient families and the psychiatry liaison team to manage behavioural issues.

**Endoscopic procedures were performed in line with professional guidance.** The service had recently been assessed by the Joint Advisory Group for gastrointestinal endoscopy and had met their standards of care and treatment. This was a national organisation which set standards of care for patients undergoing endoscopy. They inspected services to assess levels of care and treatment provided.

The service had developed cancer pathways for patients who needed them. These were led by a consultant, specialist nurse and cancer manager. The team worked with the cancer alliance and support groups to provide relevant care and share good practice.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service adjusted for patients’ religious, cultural and other preferences. Patients’ nutritional needs were assessed on admission using a malnutrition universal screening tool (MUST). We saw these were completed and information was transferred to patient care plans. Patients had their weight recorded as part of the assessment. An audit of MUST document was carried out in 2018 and showed improvements when compared with results from 2017. This included increased rates of screening within 24 hours of admission from 60% in 2017 to 71% in 2018.

**Specialist support was available from dietitians and speech and language therapists.** Staff told us how they would access special diets for patients clinical, religious or cultural needs. Patients who had suffered a stroke and needed an assessment of their swallow reflex were referred to the speech and language therapy department. Staff told us responses were prioritised on need and often occurred on the same day as the referral. Recommendations were documented in patient records and highlighted for staff to see at bed spaces and at handovers. Patients who had difficulty using cutlery could order finger food which was easier for them to manage and promoted their independence.

**All the ward staff worked as a team at meal times to ensure patients received their meals at the appropriate temperature.** Specially trained volunteers helped patients who needed support to eat and drink.

Patients with diagnoses of dementia had access to brightly coloured glasses. The aim of these were to help remind patients to drink water or fluids during the day and to ensure that the glasses were not overlooked by patients who may feel thirsty but overlook a clear glass.

We saw nutritional and fluid intake was monitored by staff and documented for authorised staff to review. Patients in the discharge lounge who were waiting to for collection were provided with a choice of meals and drinks during their stay.
Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Patients’ pain was managed using tools and methods in line with the national guidance such as the Faculty of Pain Medicine’s core standards for pain management (2015). A scoring system was used from one to ten with one being the least pain. Staff asked about pain in a way patient could understand and by observing patient expression and body language. We saw pain was documented on patient NEWS charts and appropriate action was taken.

A lead nurse specialising in pain management was available to support nursing staff and patients with managing pain.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

The inspection of 2017 identified that audits were not effectively reviewed, shared or actions taken. At our visit in 2019 we found a range of audits had been undertaken locally to monitor the effectiveness of patient care and treatment and the service contributed to national audits. We saw action plans were developed and reviewed following these audits. There were specialist groups which reviewed detailed audit results and drove improvements for the service. This was particularly evident for management of sepsis and the deteriorating patient. We saw how information was shared with staff and hospital visitors to raise awareness of steps they could take to reduce the risks for patients. Posters and information was displayed around the hospital in corridors on lift doors and at ward entrances on hand hygiene and sepsis recognition.

Matrons worked on a ward each Wednesday and later met to discuss areas for improvement. This included results from safety thermometer information such as patient falls, hand hygiene and pressure ulcer care. Matrons decided how they could improve and shortfalls in care and we saw records reviewing these actions.

The clinical effectiveness group reviewed any new audits. This group monitored audits, their progress and looked at how to reduce the potential of duplicated audits across the trust. This group also discussed results against national audits. We viewed documented discussions on results of the national cardiac arrest audit for Quarter two of 2018. This identified the rate of cardiac arrests in the hospital were higher than other hospitals in England. It also showed the predicted survival rate was higher than the trust had achieved. Numbers audited were small but showed two patients (7.7%) had been successfully resuscitated and were able to return home after treatment. This information was reviewed in detail and actions were identified. One concern was a lack of involvement of consultant input in decision making of care. An action identified was to improve the treatment escalation plan and reimplement this across the wards. These forms needed to be completed by a consultant within 24 hours of patient arrival and would provide clarity on options of care and patient choice of treatment.

The service contributed to the national improvement initiatives (CQUINs) set by NHS England. Some of the improvements for the medical care service included timely identification and treatment of patients with sepsis in acute inpatient settings and antibiotic review between 24-72 hours of patients with sepsis.

Not all therapists were using nationally recognised patient outcome measure tools to identify the effectiveness of their treatments. Physiotherapists were using patient outcome
measures to monitor progress. They were trialling the hierarchical assessment of balance and mobility which was specific to physiotherapy practice. The trial had started only two weeks previously and was still being reviewed and monitored for its effectiveness.

Occupational therapists told us they had stopped using their outcome measure tool two years previously. This was because of licensing regulations to use the tool and they had not identified another suitable tool to use in its place.

Relative risk of readmission

The risk of readmission after care and treatment in the service was worse in some areas, than would be expected when compared nationally.

From September 2017 to August 2018, patients at the trust had a lower than expected risk of readmission for elective admissions.

Of the top three specialties by number of admissions:

- General medicine had a higher than expected risk of relative readmission for elective admissions.
- Gastroenterology had a higher than expected risk of relative readmission for elective admissions.
- Medical oncology had a lower than expected risk of relative readmission for elective admissions.

Elective Admissions – Trust Level

From September 2017 to August 2018, patients at the trust had a lower than expected risk of readmission for non-elective admissions.

Of the top three specialties by number of admissions:

- General medicine had a lower than expected risk of readmission for non-elective admissions.
- Stroke Medicine had a higher than expected risk of readmission for non-elective admissions.
- Geriatric medicine had a higher than expected risk of readmission for non-elective admissions.

Non-Elective Admissions – Trust Level
The trust monitored readmission rates for patients in medical care. This was identified as a risk on the risk register and mitigating actions identified to promote safe discharges and reduce readmission rates.

**Sentinel Stroke National Audit Programme (SSNAP)**

Weston General hospital took part in the quarterly sentinel stroke national audit programme. On a scale of A-E, where A is best, the trust achieved grade C in the latest audit, July 2018 to September 2018. This result was worse than the data available at the inspection in 2017 when the overall rating was grade B. It should be noted that this analysis is based on team centred scores only, in the majority of areas and not with the addition of person centred scores.

**Weston General Hospital**

<table>
<thead>
<tr>
<th>Team-centred KI levels</th>
<th>Apr-Jun 18</th>
<th>Jul-Sep 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Scanning</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>2) Stroke unit¹</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>3) Thrombolysis</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>4) Specialist Assessments</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>5) Occupational therapy</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>6) Physiotherapy</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>7) Speech and Language therapy</td>
<td>E</td>
<td>E</td>
</tr>
<tr>
<td>8) MDT working</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>9) Standards by discharge</td>
<td>A</td>
<td>A</td>
</tr>
</tbody>
</table>

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

*(Source: Hospital Episode Statistics - HES - Readmissions (01/09/2017 - 31/08/2018))
10) Discharge processes

Team-centred SSNAP level (after adjustments)

Team-centred Total KI level

Overall scores

SSNAP level  
Case ascertainment band  
Audit compliance band  
Combined Total Key Indicator level

1 Included in IM reporting, indicator SSNAPD02

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

In March 2019, over 86% of patients diagnosed with a stroke spent 90% of their time on the stroke unit. This meant they were cared for by staff with experience and additional training in caring for stroke patients.

Lung Cancer Audit

The trust participated in the 2017 lung cancer audit and the proportion of patients seen by a cancer nurse specialist was 85.0%, which did not meet the audit minimum standard of 90%. However, this was an improvement on the 2016 figure which was 48.5%.

The proportion of patients with histologically confirmed non-small cell lung cancer (NSCLC) receiving surgery was 16.8%. This is within the expected range. The 2016 figure was worse than the national level.

The proportion of fit patients with advanced (NSCLC) receiving systemic anti-cancer treatment was 42.0%. This is within the expected range. The 2016 figure was not significantly different to the national level.

The proportion of patients with small-cell lung cancer (SCLC) receiving chemotherapy was 69.6%. This was within the expected range. The 2016 figure was not significantly different to the national level.

The one-year relative survival rate for the trust in 2016 was 33.7%. This was within the expected range. The 2016 figure was significantly worse than the national level.

(Source: National Lung Cancer Audit)

The above figures show improvement in the management of lung cancer patients in three of the areas audited and similar to expected ranges in the remaining metric. The trust had staff in post who led on cancer actions and improvements who had aspirational plans to improve the service.
They were working with a neighbouring trust to increase the capacity for breast cancer patients. Oncology, Staff attended regional cancer networks to share good practice and improve outcomes for cancer patients.

Patients were encouraged to feedback their comments on care while undergoing cancer treatments. This had contributed to reduced waiting time for therapy. Staff had fed back patient comments and pharmacy staff were involved in improving this with additional staff recruited and improving communications between ward and pharmacy.

National Audit of Inpatient Falls 2017

The crude proportion of patients who had a vision assessment (if applicable) was 100%. This met the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 0%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 0%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients with a call bell in reach (if applicable) was 89.7%. This did not meet the national aspirational standard of 100%.

(Source: Royal College of Physicians)

There was a falls lead for the hospital who had recently taken on the role from the associate director of nursing. Following the above audit results a falls action plan had been developed. The falls prevention policy had been reviewed and updated. Numbers of patient falls per ward were discussed and patient risk assessments were being more closely monitored by matrons and ward managers. We saw display boards on wards giving information on number of falls for the service. There was a plan to provide staff with keyring size basic information on actions they could take for easy reference.

Competent staff

The service made sure staff were competent for their roles.

New staff completed a corporate induction and continued to complete a competency workbook. New bank and agency staff completed an induction checklist for the ward they were working on. This was signed by the nurse in charge and record retained on the ward.

Students were assigned a mentor and spoke highly of the support they received. However, we observed an occasion when an unregistered member of staff completed tasks unsupervised. This involved nursing staff who were waiting for their registration number administering medicines without the supervision of a registered nurse and was not in line with Nursing and Midwifery Council guidelines. We raised this as a concern at the time of our inspection and the matron acted on the information to ensure staff knew this was not in line with trust policy.

Volunteer staff received an induction to the hospital after which, they could offer support to staff and patients. They also helped patients who needed support with eating and drinking but attended specific training before supporting any of these patients.

Specialist nurses had undertaken additional training for their roles and kept up to date with national developments in their field. They shared their knowledge and skills with ward staff and medical staff by providing learning opportunities for staff to attend. Information was also displayed on ward boards and personal support was provided for all staff when needed. We saw
display boards highlighting actions staff could take to reduce the number of patient falls and of pressure ulcer development.

Staff who worked on the oncology and haematology day unit had completed the United Kingdom oncology nurse specialism training. They had attended two study days and were supervised for at least three months before they could administer chemotherapy without supervision. They received psychology training and were additionally supported by a newly appointed psychologist dedicated to the cancer service.

**Support for junior doctors was provided and had been improved.** We saw feedback from junior doctors that they had previously felt unsupported by their senior medical staff when caring for the elderly. The trust had responded to conditions applied by Health Education England in 2017 to improve support. A consultant had been recruited for care of the elderly and was providing support for junior doctors. This was confirmed during conversations with junior doctors at our visit in 2019.

**Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.** Appraisal rates were below the trust target. When we met with the leadership team for medical care they informed us they monitored appraisal and training rates.

The figures below show staff appraisal rates for the whole of the urgent and medical care service and includes the emergency department. The medical care service, for example, wards, stroke units and therapy staff were not separated from the emergency department. We spoke with staff who told us they received appraisals annually and could raise issues with their manager if they felt they needed to. We saw how ward managers were keeping their own records to monitor staff appraisal rates and ensuring they were up to date.

**Appraisal rates**

For February 2019, 84% of staff within urgent and medical care at the trust received an appraisal which was just below the trust target of 85%.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Appraisals required</th>
<th>Appraisals complete</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Dental</td>
<td>34</td>
<td>27</td>
<td>79.4%</td>
</tr>
<tr>
<td>Registered Nursing Staff</td>
<td>163</td>
<td>148</td>
<td>90.8%</td>
</tr>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>35</td>
<td>25</td>
<td>71.4%</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>164</td>
<td>141</td>
<td>86%</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>123</td>
<td>96</td>
<td>78.1%</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>60</td>
<td>52</td>
<td>86.7%</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>8</td>
<td>8</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Multidisciplinary working**

All disciplines of staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
Staff assessed patient needs and contacted other specialty services for additional support. Nursing staff referred patients to physiotherapists, dietitians, speech and language therapists and mental health colleagues if there was an indication more support was needed. We saw specialists in palliative care on the wards discussing cases with medical and nursing colleagues. Nursing staff consistently stated referrals were responded to promptly.

Staff had access to psychiatry liaison teams and support from the intensive support team (a local mental health crisis team) when the liaison team had closed. Staff reported prompt access to mental health professionals to help them meet patient’s mental health needs. The psychiatry liaison team had only breached their response time targets twice in the year before this inspection. Palliative nursing staff had active inks with external organisations such as GPs and local hospice services. These nurses attended weekly meetings with the hospice service. This helped them to provide appropriate care for patients in need of their service and be aware as soon as there was available space for a new patient.

**There were weekly multi-disciplinary meetings between nurses, nurse specialists, therapists medical staff, and social workers.** This helped to make decisions regarding individual patient care and treatment and plans for discharge.

All the wards we visited had discussions twice daily about each of the patients’ needs and were attended by medical staff, therapists and nursing staff. They provided updates on the condition of each patient and focussed on plans of care and discharge. This would prompt any additional referrals that were needed to support the care of the patient. Discharge arrangements for patients who were medically fit for discharge but needed further rehabilitation or social care were discussed at this time.

Staff were clear about who had responsibility for each patient. The consultant with responsibility for a patient’s care was noted on the name board by the patient’s bed.

The service avoided discharging patients at night particularly if they were older or had complex needs and staff understood how difficult this could be for confused, elderly or vulnerable patients.

**Seven-day services**

**The service provided care and treatment seven days a week which met national standards, although not in every aspect of the service.** The service had completed an assessment of where gaps in the seven-day service were and actions taken to meet the need.

**Patients were reviewed by consultants in line with national standards.** We saw patient records which supported the timeliness of patient review by consultants. Consultant physicians were on site from Monday to Friday and offered support to staff and patients on an on-call basis at evenings and at weekends. Consultants reviewed unwell patients daily and other patients at least twice weekly. Registrars and junior doctors were available to see patients during evenings and at weekends and were confident to call a consultant if they needed further advice. Consultants would attend at weekends to review new patient admissions or unwell patients.

**Diagnostic services were available for inpatients seven days a week.** This included X-ray, ultrasound, computerised tomography (CT) and endoscopy.

Any patients who were suspected of having experienced a stroke were taken directly to the CT scanner by ambulance personnel. The specialist stroke nurse stayed with the patient during thrombolysis (clot busting treatment) until the patient was transferred to the stroke unit. This service was only available Monday to Friday during normal working hours. Outside of these hours arrangement was made for patients to receive care and treatment at a neighbouring trust.
Therapy services were limited over the weekend. Physiotherapy staff provided a service for respiratory patients for part of Saturday and Sunday. There were no other therapy services over the weekend.

Mental health services were available seven days a week in the form of a crisis team.

The medical day case unit was open Monday to Friday from 9am to 5pm. The ambulatory care unit was open Monday to Friday 9am to 7pm.

A critical care outreach team was available 24 hours of each day to support patients whose condition was deteriorating and further treatment was needed.

Health promotion

Staff provided health promotion information for patients to support them to manage their conditions and health choices.

When risk factors were identified patient options were discussed with patients to support health improvement. Patients who smoked were provided with advice on health impacts and offered strategies to quit smoking if they chose this option.

Patients who may need extra support on their discharge were referred to support agencies. Patients approaching the last months of their life were referred to palliative care specialists and hospice services were engaged if they were needed.

Macmillan nurses were based in the hospital and supported patients with holistic needs. They were available to offer advice for staff in care planning for cancer patients.

Admiral nurses supported patients with ongoing care needs. We heard how they had involved community social and housing organisations to support patients remaining safely in their own home.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

Mental Capacity training was mandatory for all staff and although training compliance did not meet the trust target staff we spoke with were clear about their responsibilities.

The trust reported that as of November 2018 Mental Capacity Act (MCA) training was completed by 80% of staff in medicine compared to the trust target of 90%.

Over the same period Deprivation of Liberty Safeguards training was completed by 74.1% of staff within medical care, compared to the trust target of 90%.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Although training compliance did not meet the trust target, staff were knowledgeable about the process. We reviewed records and found mental capacity assessments clearly documented. Patients who had made decisions about potential resuscitation had these documented in line with the trust policy. It was clear that relatives had been involved in these discussions.
Patients who were unable to make decisions about their care had deprivation of liberty safeguards in line with national guidance and documents were retained in the patient clinical record. Applications needed to be made to the local authority to allow the service to legally detain patients in their best interests when they could not make their own decisions. We saw that an application to the local authority for deprivation of liberty safeguards had been made in a timely way. Staff had missed putting the contact details of the patient’s family on the form, but corrected this as soon as we brought it to their attention and had updated the local authority appropriately.

Is the service caring?

Compassionate care

Staff cared for patients with compassion, dignity and respect. We observed patients being treated with care and respect throughout their stay in hospital. During our inspection we saw excellent communications between staff, patients and their relatives. Staff were open, friendly and approachable and they were caring, respectful and compassionate. The staff were skilled in talking with and caring for patients. We observed all members of the multi-disciplinary team had a good bedside manner and welcomed patients and their relatives to ask questions. Care from the nursing, medical staff, therapy staff and support staff was delivered with kindness and patience.

We also met two gentlemen on different wards whose wives were also in hospital on different wards. Nurses, where possible, made arrangements so they could visit each other and have evening meals together. The patients were grateful that despite the nursing workloads staff would go to these lengths to brighten their days.

Staff took the time to communicate with patients and those close to them, in a respectful and considerate manner. For example, we saw healthcare staff checking on patients in a gentle, kind and dignified manner. They involved and encouraged both patients and relatives as partners in their own care. We saw nurses encouraging patients to improve their mobility with patience and clear explanations, and positively praise patients when they reached their goals. Staff understood and respected the personal, cultural, social and religious needs of patients; we saw these being discussed in relation to their care needs during handovers and multidisciplinary meetings.

Staff introduced themselves to patients and their carers in line with National Institute for Health and Care Excellence, QS15 Statement 3: Patients are introduced to all healthcare professionals involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare team.

The patients we spoke with were positive about the compassion and kindness of staff, and their dedication to giving good care. The comments we received included, “the nurses are amazing… I don’t want to leave”, “I see the doctor every day, and he explains what is happening to me”, and “this is the best hospital I’ve ever been to. The staff are all so kind”.

During the inspection we saw staff responded in a compassionate and timely way when patients experienced pain, discomfort or distress. We saw nursing staff talking to patients calmly, and staying with patients until they were reassured.

We saw good attention from all staff to patient’s privacy and dignity. Curtains were drawn around bed spaces for intimate care or procedures and doors were closed in side rooms when necessary. Voices were lowered to avoid confidential or confidential information being overheard. All patients said their privacy and dignity was maintained.

Friends and Family test performance
The trust used the NHS friends and family test to find out if patients and their relatives would recommend their services to friends and family if they needed similar treatment or care.

The friends and family test response rate for medical care at the trust was 45%, which was better than the England average of 25% from October 2017 to September 2018.

The medical wards were:

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp Rate</th>
<th>Percentage recommended</th>
<th>Annual perf</th>
</tr>
</thead>
<tbody>
<tr>
<td>DAY CASE</td>
<td>4,150</td>
<td>99%</td>
<td>99%</td>
<td>97%</td>
</tr>
<tr>
<td>HARPTREE</td>
<td>456</td>
<td>94%</td>
<td>96%</td>
<td>92%</td>
</tr>
<tr>
<td>BERROW</td>
<td>334</td>
<td>90%</td>
<td>89%</td>
<td>83%</td>
</tr>
<tr>
<td>KEWSTOKE</td>
<td>312</td>
<td>100%</td>
<td>100%</td>
<td>93%</td>
</tr>
<tr>
<td>MEDICAL DAY</td>
<td>277</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>SANDFORD</td>
<td>227</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>UPHILL</td>
<td>211</td>
<td>85%</td>
<td>96%</td>
<td>100%</td>
</tr>
<tr>
<td>STROKE UNIT</td>
<td>144</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Key:

- Highest score to lowest score
- 100%
- 50%
- 0%

1. The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above), as well as wards where there were less than 100 responses in total over the 12-month period.

2. Sorted by total response.

3. The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

Emotional support

Staff provided emotional support to patients to minimise their distress. Staff understood the impact the care, treatment or condition might have on the patient’s wellbeing and on those close to them both emotionally and socially. Staff talked about patients compassionately and with knowledge of their circumstances and those of their families.

We saw staff answering call bells swiftly, and taking time to listen to patients’ requests and questions. We saw nursing staff supporting patients, encouraging them to ask questions, giving answers and checking that patients understood what they had been told.

We saw staff giving emotional support to patients and their relatives during their visit to the wards. Patient’s individual concerns were promptly identified and responded to in a positive and reassuring way. We saw housekeeping staff on the stroke unit speaking respectfully to patients and giving them time to respond, which helped patients maintain their dignity.

Patients also had access to physiotherapists and occupational therapists that provided practical support and encouragement for patients with both acute and long-term conditions. Patients spoke highly of the therapy staff and told us of the help and support they received from them.

Staff supported patients with mental health needs who became distressed in an open environment, and helped them to maintain their privacy and dignity.

There was good support from the hospital multi-faith chaplaincy team who were on call at all times for patients and their family and friends.

Understanding and involvement of patients and those close to them
Staff involved patients and those close to them in decisions about their care and treatment. We saw staff explaining things to patients in a way they could understand. The patients spoken with felt well informed as to their diagnosis and care plans, they felt their management was being discussed with them as much as possible. Patients we spoke with said that staff explained things to them and one patient said the doctor had been excellent when describing their condition. They said that they were confident about the information they had received.

Patients were involved with their care and decisions taken and patients we spoke to told us they had been kept informed of their care plans, and knew when they were to be discharged, and felt they were well informed. Patients we spoke with told us they were involved in multidisciplinary meetings, handovers and discharge planning.

Staff showed understanding and a non-judgmental attitude when caring for or talking about patients with mental health needs or learning disabilities. Patients and carers said staff communicated with them at an appropriate level and they were able to understand their care and treatment plans. This made patients and their relatives feel valued and engaged in episodes of care. This is in line with National Institute for Health and Care Excellence, QS15 Statement 2: Patients experience effective interactions with staff who have demonstrated competency in relevant communication skills.

Staff had access to communication aids via the learning disabilities team to help patients become partners in their care and treatment.

Staff made sure patients knew who the staff were and what they did. All healthcare professionals involved with the patient’s care introduced themselves and explained their roles and responsibilities.

Is the service responsive?

Service delivery to meet the needs of local people

The trust tried to plan and provide services in a way that met the needs of local people, however they were restricted by the uncertainty of the future for the surgical service and the whole trust. As recognised by staff, the main difficulties facing the trust were the impending reorganisation of services and the uncertainties which implicated on local planning. This was having a negative effect on staff morale and retention in some areas of the trust.

There was a winter plan to support the hospital through the winter period, defined as beginning of November 2018 through to end of March 2019. This outlined the plan and actions to help the trust be resilient during times of pressure. The trust had a frailty service which was operational Mondays to Fridays from 10am to 8pm.

The facilities and premises were mostly appropriate for the services that were delivered. Patients had access to limited gym equipment on the unit, as well as a gym room. These facilities were located on another floor and therapists used the travel between areas as additional therapy for suitable patients.

Meeting people’s individual needs

The service took account of patients’ individual needs. Patients were treated as individuals with treatment and care being offered in a flexible way and tailored to meet their individual needs. The trust used a patient clinical administration system, which had the ability to add alerts to the patient details such as identifying a patient living with dementia. Additional needs were also
highlighted on the electronic ‘white boards’ used on all wards to ensure staff were aware of patients living with additional needs.

**Adjustments had been made on wards to make them more dementia friendly.** Snacks and finger foods were made available for patients living with dementia. This allowed them to eat throughout the day to ensure they received sufficient nutrition. Nutritional guidelines for patients with dementia in hospital were available to ward staff, and were championed by dietetic staff. This included preparing for meal times, helping with feeding, and encouraging adequate fibre intake. We saw staff following these guidelines during the inspection. We also saw staff using a ‘likes and dislikes: food and drink’ form.

Patients were assessed for dementia using assessment tools. Wards were either using the ‘this is me’ booklet, or ‘about me’ booklet for those patients living with dementia. These could be used to record details about a person who can’t easily share information about themselves. For example, it can be used to record a person’s cultural and family background; important events, people and places from their life; and their preferences and routines. The trust had worked with Dementia UK to jointly fund an Admiral Dementia Nurse and was developing and supporting dementia care initiatives across the trust.

**The trust provided a framework to support communication with patients and carers who were non-English speakers, people for whom English was a second language, people with hearing or visual impairment, or who had learning disabilities.** Staff were knowledgeable about this framework. The policy set out clear standards to promote good practice and covered the use of face-to-face interpretation, telephone interpreting, and written translation services. Interpreters were available and could be arranged prior to a patient visit if known.

Patients also had access to the ‘Stroke Café’ which was held once a month in the hospital, supported by the Stroke Association. This was for stroke patients, families and carers for support. We saw leaflets available on the stroke ward for the café, and support for recovery, and for coping with the emotional effects of stroke.

**There were arrangements for caring for patients with mental health, dementia or learning disability.** There were flags on the electronic board system to alert staff there were additional needs for these patients, to enable this to be considered when providing care and treatment.

For patients living with a learning disability a proforma was used addressing and capturing reasonable adjustments, medication checks, unmet needs, resuscitation status, Mental Capacity Act, end of life status and general review. There were easy read department booklets and pictorial menus. Communication books were being developed to help with learning disabilities, any cognitive impairment, non-English speaking patients and the hard of hearing.

The service also had appropriate discharge arrangements for patients with complex health and social care needs. Staff ensured the onward care team supported them to plan the discharge of patients with complex needs.

Clinical, therapy teams and social workers were involved in getting patients home safely. For those patients needing a longer period of rehabilitation this might be provided at home or in the community.

**The chaplaincy department provided pastoral, spiritual and religious support for patients, families and staff.** They provided support for all faiths (and none) and kept close contact with faith leaders in the community. There were chaplains giving a 24-hour emergency on-call service and lay volunteers. There were trust procedures for emergency marriages in hospital.
There were regular activities on the medical wards including weekly tea parties, exercise and activity sessions, games, bingo and quizzes.

Peoples individual needs were considered with regards to food and drink provided, and support needed with eating and drinking. Snacks and hot and cold drinks were available for patients in addition to the regular breakfast, lunch and evening meal. There was also a 24-hour service to meet patients’ needs at other times of the day or night. The service made adjustments for patients’ religious, cultural and other preferences. Additional menus were available for example: snack and nourishing drinks menu, finger food menu, texture modified menus and low residue menu. There was a protected mealtime policy and this practice was encouraged in ward areas. We saw housekeeping staff making sure patients received the appropriate food on the appropriate coloured trays to identify which patients required a special diet or assistance with eating their meals.

Access and flow

Patients did not always have timely access to initial assessment, diagnosis or urgent treatment.

The systems to promote patient flow were not effective. The trust monitored bed occupancy (how many beds were occupied). Between January 2018 and January 2019, the bed occupancy averaged at 96.1%, higher than the trust target on 95%. In November 2018, December 2018 and January 2019 bed occupancy reached 99%, 103% and 114% respectively. Bed occupancy above 100% represents the use of extra capacity beds in wards designed for the purpose.

A representative from the senior hospital management team, an operations staff lead and divisional and ward leaders attended capacity review meetings (also referred to as ‘bed meetings) four times every day. We attended these meeting during our inspection and found them to be well attended. Staff used data to identify the predicted level of attendance and identify the number of discharges needed to ensure a flow of patients through the hospital. The process of admission varied to include admissions through the emergency department and planned admissions. The varied admission routes were included in the prediction of flow, as well as a review of the use of the discharge lounge. These meetings included a review of staffing levels to ensure sufficient staff with the right skills were working to meet ward demand and to give managers an opportunity to raise concerns. Overnight patient flow of the hospital was managed by the hospital site manager.

People with the most urgent needs did not always have their care and treatment prioritised. The stroke unit also had one ‘hot bed’ for use for patients who had a stroke and were admitted from the emergency department. However, this hot bed was mostly used by other patients because of flow issues within the hospital.

Staff said that where possible, they planned discharges for patients to ensure they left hospital with the medicines they needed, and made the appropriate people (such as any healthcare teams and relatives) aware that the patients discharge was approaching and the date and time. They said that for some of their patients, they had less time to arrange discharge from hospital as they were relying on packages of care in the community to be arranged. This could mean those patients were discharged at shorter notice once their package of care was in place.

The trust did have a discharge lounge where patients could be transferred to on the day of discharge to await medicines to take home and/or transport. However, this was not well utilised.
The trust had a target of discharging at least 30% of patients in the morning, but this had not been achieved in any month between January 2017 and January 2018. We saw nursing staff in the discharge lounge were caring for patients while they were waiting for their transport home. They were able to offer hot and cold drinks, snacks and sandwiches at lunchtime.

Discharge planning commenced when patients were admitted to hospital with a view to working towards a smooth and timely discharge. The trust had a discharge team, including five discharge case managers and three assistants. A social worker also worked on site four days a week to help with discharge of patients with complex needs. Case workers attended board rounds to identify potential patients who could be discharged within the following 24 to 72 hours. They also attended the 8.30 bed meeting every morning.

There were a high number of patients who remained in hospital for more than seven days. These patients are referred to as ‘stranded patients’ although it should be recognised some patients may need to remain in hospital for more than seven days. The trust target was for less than 18% of patients to be in hospital for over seven days. However, they had not achieved this in any month from January 2018 to January 2019.

**Average length of stay**

**Trust Level**

From October 2017 to September 2018 the average length of stay for medical elective patients at the trust was 11.1 days, which is higher than the England average of 5.9 days.

Of the top three specialties by number of admissions, the average length of stay for:

- General medicine was higher than the England average.
- Gastroenterology was lower than the England average.
- Geriatric medicine was higher than the England average

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

![bar chart showing average length of stay for medical elective patients at the trust compared to the England average](chart)

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

From October 2017 to September 2018, the average length of stay for medical non-elective patients at the trust was 5.8 days, which is lower than the England average of 6.3 days.

Of the top three specialties by number of admissions, the average length of stay for:

- General medicine was similar to the England average.
- Stroke Medicine was lower than the England average.
- Respiratory medicine was lower than the England average.

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

![bar chart showing average length of stay for medical non-elective patients at the trust compared to the England average](chart)
Referral to treatment (percentage within 18 weeks) - admitted performance

From December 2017 to November 2018 the trust’s referral to treatment time (RTT) for admitted pathways for medicine was better than the England average.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

Four specialties were above the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastroenterology</td>
<td>100.0%</td>
<td>93.5%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>100.0%</td>
<td>96.7%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>100.0%</td>
<td>93.9%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>97.1%</td>
<td>95.0%</td>
</tr>
</tbody>
</table>

No specialties were below the England average for admitted RTT (percentage within 18 weeks).

(Source: NHS England)

Patient moving wards per admission

From April 2018 to July 2018, the information extracted from the patient system used by the trust reported that there were no patients in the period reviewed that had been moved from one ward to another for a non-clinical reason in medical care.
However, the trust states that there is not a detailed enough report to be able to quantify this statement but has been manually reviewed and to the best of the personal review it would appear that all patients moves have been for a clinical reason.

The trust also told us patients may be moved to Waterside ward as this has single room availability and may be appropriate for the patient to be placed here. However, Waterside ward was mainly used for surgical patients. Medical patients were screened for infection risks before they were placed in Waterside ward to ensure there was minimal risk for surgical patients.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. There were policies and processes to appropriately investigate, monitor and evaluate patient’s complaints. We heard of examples where learning from complaints had helped improve the service.

Staff were encouraged to try and resolve concerns as they arose. The staff we spoke with were all aware of the trust complaints system and the service provided by the hospital’s patient advice and liaison service and complaints team. Staff were able to explain what they would do when concerns were raised by patients or their relatives. They said they would always try to resolve any concerns as soon as they were raised, but should the patient remain unhappy, they would be directed to the ward manager or the trust complaints’ process.

Patients knew how to make a complaint if they needed to and felt they could raise concerns with the clinical staff they met. Most patients told us if any issues arose they would talk to nurses available.

Staff we spoke to could give us examples where learning had happened following a complaint, including improved lighting in side rooms, and improved induction for nursing agency staff.

Information about making complaints was available in all medical areas we visited. ‘A Guide to Giving Feedback or Making a Complaint’ leaflets were available on all wards and information could be accessed on the trust website with details about how to resolve concerns quickly and how to make a complaint. The leaflet was also available for people who required the information in other formats and font sizes. Interpreters or signers were available for those requiring access. Complaints could be made in person, by telephone, email, or letter.

Summary of complaints

From December 2017 to November 2018 there were 46 complaints about medical care. The trust took an average of 49 days to investigate and close complaints. This was not in line with their complaints policy, which states complaints should be closed within 40 working days.

A breakdown of complaints by subject can be seen below:

<table>
<thead>
<tr>
<th>Subject of complaint</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>All aspects of clinical treatment</td>
<td>14</td>
</tr>
<tr>
<td>Admission, discharge and transfer arrangements</td>
<td>9</td>
</tr>
<tr>
<td>Patient Care</td>
<td>5</td>
</tr>
<tr>
<td>Attitude of staff</td>
<td>4</td>
</tr>
</tbody>
</table>
(Source: Routine Provider Information Request (RPIR) – Complaints tab)

**Number of compliments made to the trust**

From December 2017 to November 2018 there were 202 compliments within medicine. The top three wards for compliments were Berrow (91), Harptree (37) and the Stroke unit (34).

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

### Is the service well-led?

#### Leadership

Managers for the medical care division had the abilities but did not always use the right skills to run a service providing high-quality sustainable care.

The medical care was delivered as part of the emergency medicine directorate, which was led by an associate medical director, general manager and nursing manager. The CQC inspection of 2017 reported a disconnect between ward staff and directorate leaders. There had been some recent changes in management of the service and staff reported having had four general managers over a two-year period. Staff at the 2019 visit said they would recognise the directorate leads but were not confident issues would be dealt with. Staff told us of occasions they had approached senior leadership and had attended meetings to voice their concerns. However, no changes had been made and further feedback had not been provided.

The CQC report of 2017 expressed how matrons had felt overstretched in their roles with duties too varied to be able to make changes and service improvements. Leadership at matron level had been reorganised in 2018 into operational management and quality and safety management for the service. This provided a more specific focus for matrons in those roles. Management at matron level was provided by experienced matrons, some of whom were newly appointed to the trust. Matrons had been appointed to take forward specific subjects. For example, a lead for sepsis and the deteriorating patient and a matron to oversee quality outcomes for patients such as falls with harm.

Involvement of staff in the reorganisation of the medical service had been limited. The leadership team shared the consultation documentation of the proposed changes to the ward areas and locations. A draft letter stated that staff would have the opportunity to feed their thoughts at one to one meetings. Staff told us they had attended these meetings and felt they had not been consulted but had been asked where they would like to work; for example, in an operational role or on which ward but not for their views on the reorganisation of services.
Service leads were clear the arrangements for winter pressures ward and the Stroke unit were to continue after March 2019. However, not all staff were aware of the future for the stroke unit.

**Staff felt supported by their ward managers and matrons but not all staff felt supported by service leads.** Matrons were located close to the ward areas they had responsibility for and were visible and accessible to staff. Ward staff were clear who their line managers were and told us they were able to report any concerns to their matron and the response would be prompt. However, staff gave examples of how their managers had been dealt with by their service leads in an unsupportive way. Some matrons felt they were provided with little guidance or support in developing their roles.

Staff were aware of whistleblowing processes and who they could approach with any concerns. Staff below matron level felt they could approach any of their managers for support.

**There was a designated executive who led on mental health within the trust.** The trust had restarted their mental health operational group which met every two months. This meeting allowed staff to raise the profile of mental health care provided at the hospital.

**There was executive engagement with cancer services.** The Chief Executive Officer for the trust was the chair of the regional cancer alliance network. A clinical lead and specialist nurse led improvement for cancer services and worked in partnership with neighbouring trusts, regional networks and local community organisations. They met regularly and identified improvements for the future.

**Vision and strategy**

*The service had a vision for what it wanted to achieve and plans to turn it into action. This was developed with some involvement from staff, patients, and key groups representing the local community.*

The vision for services at the hospital was uncertain. There was a public consultation in progress at the time of our visit about how to deliver services in the area. Commissioning arrangements were uncertain and a merger with a larger trust had been under discussion. However, no plans had been finalised and staff expressed how they felt uncertain about the future of the hospital.

The trust had developed values in an acronym of PRIDE. This was to reflect high care standards, actions for reputation of the trust, innovation in care, dignity or patients and excellence. We saw documentation of proposals for improvement projects where these had been assessed as in line with the trust values.

The service maintained its own strategy to provide good patient care and we were working on areas of challenge. Recruitment drives were being undertaken to attract permanent staff in all areas and reduce reliance on agency and locum staff. Specialist nursing staff had been recruited since our inspection in 2017 and we could see how changes had been made to their processes which supported sustainable improvements. However, some of these were fixed term roles and no plans had been made for when the contracts came to an end and staff felt uncertain about their future. This meant staff were seeking employment in other organisations.

**Culture**

*Matrons promoted a positive culture that supported and valued staff, creating a sense of common purpose, based on shared values. However, staff felt if they raised issues with service leads and the executive team actions would not be taken as a result. Some staff felt undervalued by service leads.*
Ward staff demonstrated an overwhelming culture of team working and supported each other in the activities of caring for patients. We saw medical staff respectfully reminding nurses about activities or tests that needed completing. Ward clerks and other support staff noticed when clinical staff were busy and offered any support they could give. Nursing staff worked well with support staff at meal times to ensure patients received their meals at the correct temperature. Specialist nursing staff and therapists worked closely with nursing colleagues as part of the medical care team. Staff felt valued by their ward team members and were proud to work at the hospital. We heard many positive comments from staff including “I love working here”, “it’s like a family”.

The culture above matron level was less positive. We were told of numerous occasions across the service when senior staff had been reprimanded by senior managers in view of patients and other staff. Most staff we spoke with were able to raise concerns but felt actions would not be taken to improve care, at a senior level.

The majority of staff including those with protected characteristics under the Equality Act, were able to access development opportunities and had received additional training to improve their skills used for their role. Specialist nurses were attending approved national courses for their specialty and attended the appropriate network meetings to share good practice. Some staff had applied to attend development courses but been rejected. These staff felt hindered in developing leadership skills.

Staff we spoke with were confident about being open and honest with patients.

Staff wellbeing was a focus for the service. We saw staff worked well when they were busy but ensured colleagues were able to take breaks. Junior medical staff told us the guardian for safe working hours was supportive in ensuring they did not stay late on their shifts.

**Governance**

The trust used a systematic approach to continually improving the quality of its services and safeguarding high standards of care.

Governance procedures had been revised since our inspection in 2017 and included a range of meetings which discussed audit results, patient outcomes and areas for improvement. Audits were carried out by matrons, specialist nurses, medical staff and ward managers and results were fed into the integrated performance report. This was reviewed at departmental and trust level governance meetings. The service leads and matrons were positive about the renewed structure for governance although recognised it was a relatively new process and further improvements could be made. Matrons and sisters met weekly on ‘Ward Wednesday’. These meetings focussed on patient safety issues and provided a forum for senior nurses to discuss concerns and learning from incidents. Ward assurance reports which were discussed monthly and presented to directorate governance meetings and specialist working groups where the information was relevant. For example, number of patient falls per month, management of deteriorating patients and management of sepsis in neutropenic patients. Directorate leads reported to the trust board using an integrated performance reporting process.

Senior medical staff met weekly at ‘cabinet meetings’ These were meetings set up for consultants to discuss issues within their specialty. We saw these were well attended and medical staff had discussed issues together to provide solutions or had actions to seek further support from the directorate leads.

There was a service level agreement with a local mental health trust to provide mental health act liaison and to manage the paperwork used for the Mental Health Act.
Reports on cancer wait times were reported to the executive team using an integrated performance report process. The results were on a rolling basis and showed trends over the previous 12 months. This gave an oversight of key performances throughout the division and where the executive team needed to offer further support.

The cancer lead group were working towards a sustainable workforce to deliver the National Cancer Strategy by 2020. They were aware of their challenges particularly in the available workforce. There was a national challenge in recruiting senior radiologists. If plans to merge with a neighbouring trust went ahead they saw this as a method of partly resolving the staffing issue.

The clinical effectiveness group monitored audits and encouraged all staff to channel any new audits through their ‘Hub’. This gave an oversight of how effective services were and would identify if there was any duplication of audit. This group also had a focus on learning from mortality. They shared learning points from death reviews and shared this widely with staff in the trust.

**Management of risk, issues and performance**

The trust had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. However, we were not assured the systems were always used properly.

Staff were aware of how to use the system for raising risks and concerns. Risks were rated to provide priority and matrons added risks to the register in order they could be reviewed and escalated appropriately. However, we were told some risks had been reviewed and downgraded by directorate leads before they were escalated to the executive team. This had been done without any discussion of mitigating actions with, or feedback to the originator of the risk. This created a feeling of mistrust amongst staff that service leads raised issues accurately with the executive team.

Risks on the risk register for medical care were the same as the concerns that staff and managers identified. Risks had been identified regarding flow of patients through the hospital. A plan was developed for reconfiguration of medical care services which had involved changing location of wards. Planning of these services had considered areas that could be opened in times of high demand, such as during the winter when flu and respiratory problems are more prevalent. The ward moves and impact on patients and staff was still under review. For example, the stroke unit had moved to an area which had only one electronic hoist which was suitable for light/occasional use only. The hoist broke through overuse which highlighted the issue. The risk register had been recently updated to include the need for additional, suitable hoist equipment to cope with the demand.

The policy for resilience of the hospital in times of major crisis were available for staff. This included levels of major incident, actions needed and levels of command. We saw these referred to on wards we visited for staff awareness.

**Information management**

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Staff had the information they needed to safely care for patients. Electronic systems supported the movement of patients to appropriate medical beds. Staff were informed of patients who were waiting for a bed and could review their details electronically. Medical assessment unit staff reviewed patients who were waiting in the emergency department using the electronic system and could identify patients who could transfer to them directly. Risks for patients were clearly
identified for all staff to see. They used symbols on boards and at bed spaces to identify patients at risk of falling, with dementia or special diets needed.

**Service leads, matrons and managers understood the performance reports and the impact on patients.** They were able to interpret performance reported about patient safety and what actions would improve outcomes. Staff considered sustainability and quality but had to make compromises when staff were not available to fill shifts. Leads anticipated an improvement in general ward staffing when the winter pressures ward closed. They were aware a greater number of staff needed to be recruited to prevent the pressures on staff in the next winter period.

All staff we spoke were aware of how to access information. Audit results and learning from incidents were shared with staff using ward meetings, newsletters and emails.

All public board reports were easily available on the trust internet and web pages.

**Engagement**

**The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.**

Wards and units sought feedback from patients and carers which included Friends and Family Feedback. Information was collated and discussed at governance meetings. Numbers of feedback forms were generally reported as low but comments from patients were positive about the care they received. We saw discussions documented about how wards could improve feedback rates. Kewstoke had used quality improvement processes which had improved the numbers of feedback forms they received. They had taken steps to raise awareness of feedback forms using posters and added the action as a mandatory part of discharge. We saw how other wards used provided the feedback form to patients on their discharge. The oncology service had responded to patient views about time patients had to wait for their scheduled appointment. This had resulted in a new role of a scheduler being recruited to. The scheduler was able to focus on timings of appointments and align them to patient needs. This meant patients arrived closer to their appointment time than previously.

We saw boards at ward entrances which displayed feedback they had received and actions the ward had taken as a result in the form or ‘you said, we did’. Berrow ward had received comments about noise at night and the action ward staff were taking was to audit the noise at night in order to identify reasons and where it could be reduced. Ward staff had also ensured the name of the nurse caring for them was on the patient board behind their bed and the nurse in charge of the ward wore a brightly coloured ‘nurse in charge’ badge. This was in response to comments that patients were unsure of who was in charge of nursing shifts.

Staff attended ward meetings where they were encouraged to contribute their views. Staff who could not attend could view the discussions as an email and on newsletters. The Chief Executive of the hospital held regular meetings for staff to attend and ask questions or raise concerns. Some staff had attended and had concerns escalated. We were told these were well attended but that staff did not always have the time to raise their questions as a result.

Staff success was celebrated through annual awards and other more current awards. Monthly PRIDE awards provided recognition for staff who provided good or outstanding care. We saw displays of nominations for staff having provided good care. Staff also received recognition monthly for achieving good results managing patients with sepsis.

**Learning, continuous improvement and innovation**
The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

There was a process to encourage innovation. The trust used quality improvement methodology of plan, do, study and act for their new projects. We saw how staff used this methodology and circulated it to staff. Clear and easily readable information demonstrated how it had supported an improvement in outcomes for patients. These were in the form of quarterly produced posters, which were distributed to staff giving snapshots of projects. Kewstoke had provided information on this quarterly document about how they improved numbers of patient feedback forms returned.

The frailty team had audited their results based on reducing elderly patient’s length of stay on the ward and avoiding unnecessary admissions to hospital. They had been able to show improved outcomes for patients and had recruited to their team to provide a more sustainable service.

### Surgery

#### Facts and data about this service

The trust’s surgery service at Weston General Hospital offer a broad range of core surgical activity which includes planned (elective), emergency and day case surgery, pre-assessment area, theatres, anaesthetic rooms and a recovery area.

Areas of surgical speciality include: colorectal surgery, upper gastrointestinal surgery, breast surgery, general surgery, ear, nose and throat, trauma and orthopaedics, urology and ophthalmology.

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

A breakdown of surgical care wards/areas at Weston General Hospital is below:

<table>
<thead>
<tr>
<th>Ward/Area</th>
<th>Number of theatre / beds / trolleys</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthetics</td>
<td>N/A</td>
</tr>
<tr>
<td>Day Case Unit</td>
<td>22 trolleys and two theatres</td>
</tr>
<tr>
<td>Hutton Ward</td>
<td>27 beds</td>
</tr>
<tr>
<td>Main Theatres</td>
<td>Four theatres</td>
</tr>
<tr>
<td>Oncology day unit</td>
<td>Six chairs, two trolleys</td>
</tr>
<tr>
<td>Pre-Operative Assessment Unit</td>
<td>N/A</td>
</tr>
<tr>
<td>Steepholm Ward</td>
<td>22 beds</td>
</tr>
<tr>
<td>Waterside</td>
<td>12 beds</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>61 beds, 24 trolleys, six chairs, six theatres</strong></td>
</tr>
</tbody>
</table>

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

The trust had 9,427 surgical admissions from October 2017 to September 2018. Emergency
admissions accounted for 3,302 (35%), 4,968 (53%) were day case, and the remaining 1,157 (12%) were elective.

(Source: Hospital Episode Statistics)

As part of this inspection we reviewed trust wide processes, systems and leadership for the surgical division. We visited the following areas:

- Main theatres
- Day case unit
- Steepholm Ward
- Hutton Ward
- Waterside Ward
- Oncology Day Unit
- Pre-Operative Assessment Unit and Theatre Receiving Unit

We spoke with approximately 80 staff this included; surgical division leaders, nursing staff on theatres and in wards, medical staff to include junior doctors through to consultant level, allied health professionals, and hospital support staff.

We spoke with 15 patients about the care and treatment they had received and six relatives. We reviewed 20 patient records. We also reviewed and analysed data which was provided to us during and after the inspection. Some of which is referenced within this report.

Is the service safe?

Mandatory training

The service provided mandatory training in key skills, however not all staff were fully compliant with their training, particularly medical staff. The trust set a target of 90% for completion of mandatory training. We were informed the system used to capture this information was reporting inaccurate data and this was being reviewed by the trust at the time of our inspection.

There was a trust-wide electronic staff record where all training attended was documented. Ward and theatre sisters were informed of training completed and alerted to those staff requiring updates for mandatory training through regular discussions with the HR department. Training compliance and performance could be compared against other directorates in the trust.

Most staff we met said they were up-to-date with the trust’s mandatory training programme. They were positive about the quality and the frequency of mandatory training they received and felt they were able to access appropriate training. However, a downward trend was seen during the winter months. A number of mandatory training sessions were cancelled during this period due to increased operational pressures.

Mandatory training completion rates trust level

A breakdown of compliance for mandatory training courses as of November 2018 at trust level for qualified nursing staff in surgery is shown below. In surgery the 90% target was met for 14 of the 17 mandatory training modules for which qualified nursing staff were eligible.

<table>
<thead>
<tr>
<th>Training module</th>
<th>Staff eligible</th>
<th>Staff trained</th>
<th>Completion rate</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

120
A breakdown of compliance for mandatory training courses as of November 2018 at trust level for medical staff in surgery is shown below. In surgery the 90% target was not met for any of the 12 mandatory training modules for which medical staff were eligible, although adult basic life support was short of only one medical staff member to meet the target.

<table>
<thead>
<tr>
<th>Training module</th>
<th>Staff eligible</th>
<th>Staff trained</th>
<th>Completion rate</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Basic Life Support</td>
<td>13</td>
<td>11</td>
<td>84.6%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT</td>
<td>20</td>
<td>16</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>20</td>
<td>15</td>
<td>75.0%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>20</td>
<td>14</td>
<td>70.0%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>20</td>
<td>14</td>
<td>70.0%</td>
<td>No</td>
</tr>
</tbody>
</table>
We requested current data for mandatory training compliance, this was presented to us by surgical speciality or department. Training compliance reported on 31 January 2019 was as follows:

<table>
<thead>
<tr>
<th>Training Area</th>
<th>Target</th>
<th>Adult Basic Life Support</th>
<th>Fire</th>
<th>Health &amp; Safety</th>
<th>Infection Control</th>
<th>Moving &amp; Handling</th>
<th>Safeguarding Children</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>20</td>
<td>14</td>
<td>70.0%</td>
<td></td>
<td></td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>20</td>
<td>14</td>
<td>70.0%</td>
<td></td>
<td></td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Dementia Awareness (inc. Privacy &amp; Dignity standards)</td>
<td>20</td>
<td>12</td>
<td>60.0%</td>
<td></td>
<td></td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Fire safety</td>
<td>20</td>
<td>12</td>
<td>60.0%</td>
<td></td>
<td></td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Information Governance</td>
<td>20</td>
<td>12</td>
<td>60.0%</td>
<td></td>
<td></td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Counter Fraud Awareness</td>
<td>20</td>
<td>9</td>
<td>45.0%</td>
<td></td>
<td></td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td>20</td>
<td>5</td>
<td>25.0%</td>
<td></td>
<td></td>
<td></td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Training tab)
This identifies training compliance was falling consistently below target for medical staff, there was also under performance in pre-operative assessment, cancer specialist nurses and oncology day unit, however this may be skewed by small numbers of staff within the department. To reiterate, the trust was reviewing the data as they found some inaccuracies, for example reporting of medical staff who had left the trust, were on a rotation, or received their training elsewhere.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had access to a safeguarding lead nurse who gave good support.

Staff we spoke with were knowledgeable about the trust’s safeguarding policy and processes and were clear about their responsibilities. They described what actions they would take should they have safeguarding concerns about a patient. Staff explained how they would make safeguarding referrals and had received feedback on past referrals.

Safeguarding incidents were reported and investigated. Staff sought advice from safeguarding leads and information was provided on the intranet site for staff to refer to.

Staff received training on how to recognise and report abuse and knew how to apply it. Safeguarding training was mandatory and included the Mental Capacity, Deprivation of Liberty Safeguards (DoLS) and level one to four child protection training. The trust set a target of 90% for completion of safeguarding training. Training compliance met this target for nursing staff but was underperforming for medical staff.

Staff received training in emerging areas of concern around abuse. This included identification and escalation of suspected female genital mutilation. Staff were knowledgeable about female genital mutilation (FGM) and aware of their responsibility to report to the police suspicions of FGM.

Safeguarding training completion rates trust level

A breakdown of compliance for safeguarding training courses as of November 2018 at trust level for qualified nursing staff in surgery is shown below. In surgery the 90% target was met for each of the three safeguarding training modules for which qualified nursing staff were eligible.

<table>
<thead>
<tr>
<th>Training module</th>
<th>Staff eligible</th>
<th>Staff trained</th>
<th>Completion rate</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>92</td>
<td>91</td>
<td>98.9%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>92</td>
<td>85</td>
<td>92.4%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
A breakdown of compliance for safeguarding training courses as of November 2018 at trust level for medical staff in surgery is shown below. In surgery the 90% target was not met for any of the three safeguarding training modules for which medical staff were eligible.

<table>
<thead>
<tr>
<th>Training module</th>
<th>Staff eligible</th>
<th>Staff trained</th>
<th>Completion rate</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>20</td>
<td>17</td>
<td>85.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>20</td>
<td>16</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>20</td>
<td>14</td>
<td>70.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

**Cleanliness, infection control and hygiene**

**The service controlled infection risk well.** There were systems to monitor and maintain standards of cleanliness and hygiene, to prevent the spread of infection. There were arrangements for cleaning surgical wards, units and theatres. There were dedicated teams of cleaners who ensured these areas were clean and tidy. There were daily schedules and weekly tasks, alongside deep cleaning as and when required. Cleaning staff on wards could show us their work schedules, which included toilets, floors, bins, bed frames, PCs and phones, dispensers, sluice, trolleys and linen cupboard. There were also details of the deep cleaning and double flushing of running water. Cleaning equipment was colour coded, clean and well maintained, and stored in a locked area. However, workloads were reported to be high in all areas.

On Steepholm ward enhanced cleaning of an extra two hours a day was instigated to improve the environment following a high number of Vancomycin-Resistant Enterococcus, a bacterium causing infections. Improvements had been seen and this had been downgraded to an extra one hour per day.

There was an infection control risk to patients sharing spaces in the theatre receiving unit with patients attending their pre-operative clinic. Additional cleaning arrangements had been made for the theatre receiving unit with a deep clean programme being started in October 2018, increasing cleaning hours from two hours to three hours every night, and steam cleaning toilets. This helped to limit the risk and help cross infection.

There were some areas in main theatres which could have improved their cleanliness to include the resuscitation trolley and difficult airways trolley. Although equipment in theatres appeared clean and tidy there was not always labels to indicate equipment had been cleaned.

**Good infection control practice was observed being followed by staff.** All staff were seen to be following the trust dress code, for example in appropriate theatre clothing and bare below the elbow. Personal protective equipment (for example gloves and aprons) was readily available and used appropriately. We saw all clinical staff, including doctors, nursing staff and therapists washing their hands and using hand sanitiser gel in line with infection prevention and control guidelines. Non-clinical staff including administrative staff and cleaning staff were also seen to be
following the guidelines. Hand hygiene audits were completed monthly and reported for infection prevention control performance.

In all areas ward areas visited, the floors, walls, curtains, trolleys and areas in general were visibly clean. Bed spaces were also visibly clean in both the easy and hard to reach areas. Bed linen was in good condition, clean and free from stains or damage to the material. Equipment appeared clean and we saw green 'I am clean' labels placed on trolleys and equipment to show it had been cleaned and was ready for use. When speaking to patients and their relatives everyone commented on the frequency of the cleaning. One relative said “they're always cleaning … I’m pleasurably surprised.”

The arrangements for managing waste and clinical specimens kept people safe. Sharps bins were stored on trolleys to enable ease of use and transportation. Used sharps bins awaiting removal were closed, sealed and stored in the dirty utility. Disposable items of equipment were discarded appropriately, either in clinical waste bins or in sharp instrument containers. Nursing staff said these were emptied regularly and none of the bins or containers we saw were unacceptably full.

Environmental audits were completed monthly to review the completeness of cleaning, we reviewed an example of completed audits for the months previous to our inspection.

The hospital took part in Public Health England Surveillance and the Patient Led Assessment of the Care Environment (PLACE). The assessments involved local people known as patient assessors, assessing how the environment supported the provision of clinical care. Hutton and Steepholm wards scored 100% for cleanliness.

The risk of infection was reduced through systems and processes implemented within the service. During pre-operative assessments consideration was given on how to reduce the risk of a surgical site infection. For example: checking patient diabetic status, the taking of Methicillin-resistant Staphylococcus aureus (MRSA) and Methicillin-sensitive Staphylococcus aureus (MSSA) swabs, informing how a patient can prepare themselves, and limiting the number of people in theatre. For elective orthopaedic patients, post-surgery, they typically become patients on Waterside ward, where separate rooms helped reduce the spread of infection.

All patients preoperatively received an MRSA screening. Infection prevention control data submitted by the trust showed between April 2018 and January 2019 100% of elective patients and 89% of emergency patients were MRSA screened. The service had also introduced MSSA screening following a run of infections identified. There were processes for decolonising patients (treatments used to try and get rid of the MRSA or MSSA patients are carrying).

The incidence of infection was monitored monthly. For the surgical directorate between April 2018 and January 2019 there had been one case of clostridium difficile.

Environment and equipment

The service had suitable premises and equipment, and looked after them well. We observed equipment and the environment in all surgical areas, to include theatres and wards, and found minimal concerns for how these were managed and maintained. Staff told us they felt safe in their working environment.

The systems and processes for ensuring equipment was serviced, maintained, tested or calibrated were effectively managed. Equipment was well maintained and regularly serviced. Items requiring maintenance were on a database of planned maintenance at frequencies in line
with guidance from individual manufacturers. Items were labelled in accordance with a planned maintenance frequency to ensure users could see when items were due for service. We reviewed a random selection of equipment and it was clear the equipment had an in-date service. It was recognised on the risk register there was an out of date asset register for theatres, and thus equipment was old and required constant upkeep and repair. The asset registers were currently being updated trust wide.

We saw a range of equipment was readily available, and most staff said they had access to the equipment they needed for the care and treatment of patients. For example, bariatric equipment was available if required.

Resuscitation trolleys were accessible to all surgical areas, and regularly checked to ensure they were available and ready for use in case of an emergency. We reviewed a sample of resuscitation trolleys and confirmed daily checks were mostly complete, with full monthly checks. We did identify in main theatres the defibrillator was dusty. Also, a drug box had expired the previous day, although it had been noted on the previous check, it had not been replaced. This was rectified at the time of our inspection.

There were no adult guidelines on the difficult airway trolley. There was a risk emergency guidelines were not available to support the management of a patient, for example to help with choice of techniques or team decision making. This was raised with the theatre sister, who rectified this in main theatres at the time of the inspection. It was also noted the trolley was also very dusty.

Anaesthetists were happy with the quality of the ventilators and monitors. We observed these to be in good working order. Anaesthetic machines were checked daily, this was clearly evidenced.

Theatre equipment was sterilised off site. There were no concerns identified by staff with this process or the availability of sterilised equipment.

The operating theatres were a good size, visibly clean and relatively uncluttered. The lighting system was modern, and all equipment appeared in good working order. Main theatres included three laminar flow theatres suitable for elective joint replacement. Laminar flow aims to reduce the number of infective organisms in the theatre air by generating a continuous flow of bacteria free air.

The theatre receiving unit (where patients arrive and wait for their surgery) environment was not an ideal arrangement for infection control purposes. The theatre receiving unit was combined with pre-operative assessment. This meant screened patients attending for their surgery were mixing with non-screen patients attending their pre-operative assessment clinic. The team in the unit were managing this as best they could with the facilities they had available to them. The cleaning hours and deep cleaning had been increased, and they tried to keep patients separate particularly the use of toilet facilities.

The design and use of the facilities in the ward areas was suitable for patients following surgery. The surgical wards were observed to be visibly clean and fire exits were not obstructed. We saw sluices were locked and substances were stored in line with control of substances hazardous to health legislation. Linen stores were well stocked and organised. Sharps bins were closed and secure and out of reach of children.

There was access to the neuro physiotherapy gym when patients needed a quiet space away from the busy wards or needed to use parallel bars, standing frames, or for bannister assessments.

Assessing and responding to patient risk
Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary. Risk assessments relating to patients’ needs were completed and evaluated.

Patients attended a pre-operative assessment to assess their suitability for surgery and risks ahead of their operation date. Predominantly these were nurse-led clinics face to face or via telephone. Consultant clinics always ran for orthopaedic patients, and were also utilised by some specialities dependent on the patient. An anaesthetist-led clinic was held for higher risk patients and patients could be referred to this clinic by the nurse or consultant. Each pre-operative assessment had a 12-week expiry date, therefore patients needed to have their surgery 12 weeks after the pre-operative assessment, or completed a second pre-operative assessment. Staff told us the process worked well and it was very rare to have cancellations on the day of surgery due to unexpected medical reasons or the patient not being fit for surgery.

The American Society of Anaesthesiologists grade guidelines were followed to review patients ahead of surgery, and complete appropriate tests to assess how well a patient is likely to respond to their surgery. Stress tests could be requested, for example echocardiogram for heart function and exercise tests.

Approximately 3% of surgical admissions required an intensive care bed for a period of time following surgery. This was either planned and arranged prior to the surgery, or escalated at the time of surgery. If planned intensive care beds could be booked, staff told us this process usually worked well, except at times of major bed escalation. The proximity of the theatre recovery to critical care, and because most of the consultant anaesthetists worked in both theatre and critical care, made it easy to quickly liaise about patients unexpectedly requiring an intensive care bed post-surgery. Two of the spaces in main theatre recovery could also be used for ventilated patients.

Venous thromboembolism prophylaxis was well considered for each patient. Thromboembolic deterrent stockings were regularly used for patients undergoing surgery to prevent the risk of blood clots.

There was clear escalation of a deteriorating patient. There were processes and policies used to monitor, assess, identify and respond to patient risks. Staff were trained in the diagnosis of sepsis and recognition of a deteriorating patient. The service used nationally recognised early warning scores to help detect if a patient’s condition had deteriorated. Patients were assessed and monitored using the National Early Warning System (NEWS). This was a system to alert staff to a patient deteriorating when certain clinical ‘triggers’ were reached. Staff were knowledgeable in responding to any changes in the observations which necessitated the need to escalate the patient to be seen by medical staff. We reviewed 20 patient records and saw they had been completed according to guidance.

Staff we spoke to all knew how to escalate patients presenting with sepsis. The sepsis six pathway was in use on the wards. Sepsis six is the name given to the process followed to reduce the mortality in patients with sepsis with six diagnostic and therapeutic steps. Staff received teaching on the escalation of patients who were scoring outside certain parameters on the national early warning score (NEWS) chart and this included when to begin the sepsis six pathway. There had been a reduction of patients admitted to intensive care unit as a direct consequence of prompt management and treatment of sepsis. Patient length of stay and sepsis mortality had reduced as per the summary hospital-level mortality indicator report.

A critical care outreach team was available 24 hours a day, seven days a week. Staff on wards and theatres told us they had good access to this team and they were responsive. Staff said
there was always a rapid response to a resuscitation call with the senior sister on duty, the critical care team, doctors and anaesthetist attending.

The World Health Organisation’s (WHO) five steps to safer surgery process was well embedded and followed within theatres. Audits of the WHO checklist were completed. The recovery team audited each five steps of the WHO checklist when a patient was transferred to recovery. The theatre sisters completed audit paperwork where they observed six a month and reviewed 20 debriefs each month. Audit data reviewing all patient documentation and observational audits were 100% compliant in main theatres and day case theatres between August 2018 and January 2019. We have asked the trust to review the audit process and be assured consistently achieving 100% compliance is a true reflection of performance.

We observed three safety briefings. All were conducted professionally, and were attended by the full theatre team who were all engaged during the briefing. All cases were discussed with the surgeon describing the patients and procedures to be performed, and the anaesthetist discussed any medical problems, airway requirements, need for antibiotics, and VTE prophylaxis. The team leader confirmed correct equipment available. The process was thorough and all staff were encouraged to, and observed to contribute.

Best practice was observed in theatres. For example, in line with best practice patients had the operative site marked. Good moving and handling practices were observed in theatres. For example, in the middle of a procedure it was necessary to alter the patient’s position on the table for the second stage of the operation to take place. This was performed well by staff and an additional member of staff was borrowed from the adjacent theatre to assist.

There was a standard operating procedure document available for blood transfusion, however staff were not always aware of this. Staff attended online and in-house training for this.

Following surgery patients were taken to recovery. The handovers observed from theatre to recovery were comprehensive. Whilst in recovery monitoring equipment was connected to the patient and the patient temperature was documented. Pain charts and NEWS were completed. The recovery staff spoken with were very clear in how to escalate problems should a patient deteriorate. They used a method to monitor patients when in recovery, and were clear on the regularity of the observations dependent on the patient dependency and the outcome of previous observations. The last two sets of observations were required to be completed on a NEWS chart before the patient was transferred to an inpatient ward. We also observed handovers from recovery to ward which was detailed to ensure all relevant information was handed over.

There were effective handovers and shift changes to ensure staff could manage risks to patients. There were also safety briefings held twice each day. The purpose of the safety briefing was to alert staff to any patient care issues, concerns or risks and to give update information on policies or procedures. On Steephelm ward we reviewed the daily safety brief book used during the safety huddle. This contained information of relevance to the patients and could be used to highlight particular difficulties and concerns.

Neutropenic sepsis was well considered to assess the risk to patients. The oncology unit had completed an audit looking in to neutropenic sepsis in patients having chemotherapy. This had resulted in changes to the patient pathway, including patients at risk having a different colour cover to their notes to highlight the risk. We saw this in practice for a patient who was in theatre. We were told this was having a positive effect. Neutropenic cancer patients were isolated on the wards and the oncology department provided support.
At times of escalation patients could be placed as inpatients on wards which were not relevant to their specialty. For medical patients on surgical wards, staff said medical doctors did not always respond to see medical patients on the surgical wards.

When the hospital was in escalation patients would be inpatients on the day case unit. There were criteria for escalation of inpatients in the day case unit which included the inclusions and exclusions. Staff told us approximately 80% of the time patients were suitable for the day case unit. For the remaining 20% if they were not suitable this was normally an executive or matron approved decision and the patient would be moved to a suitable inpatient ward when possible and reported as an incident. Inpatients on the day surgery unit were reviewed by consultants in a timely way. During our inspection we observed the urology medical team attend the unit at 8am to review all the patients who were inpatients on the day case unit.

Work was considered to reduce the risk of pressure ulcers being acquired while in hospital. Physiotherapy technicians and a nursing assistant from Hutton ward had designed a training day for ward staff to develop their confidence in early movement and mobilisation of patients following trauma surgery. Audits have shown patients were out of bed by 11am. The pyjama paralysis project continued as well, this was an NHS scheme to encourage patients to change from their pyjamas into daywear. By having patients being up and dressed and moving while in hospital. This reduced the incidence of hospital acquired pressure ulcers and the ward had been seven months without a grade three or four pressure ulcer.

Nurse staffing

The service did not always have enough nursing staff, but were managing staffing gaps to ensure people were safe from avoidable harm, and to provide the right care and treatment. At the time of our inspection staffing levels and skill mix were at an appropriate level to ensure patients received safe care and treatment at all times. There was a good mix of skilled and experienced nurses and healthcare assistants on the wards.

Nursing staffing was a challenge for the trust, despite holding a number of recruiting sessions, including a trip to India. There was a focus on recruitment and retention and the recruitment from overseas was progressing. A workforce strategy and underpinning delivery plan had been in development looking at hours, flexible working and alternative posts.

The ward teams worked flexibly across Hutton and Steephelm surgical wards with staff moving between the two to alleviate agency pressures and vacancies.

The trust had processes for monitoring and ensuring safe staffing in line with current national recommendations. Staffing in theatres was planned in line with standards and guidelines for the Association for Perioperative Practice. In theatres the band six typically was the theatre lead, but the scrub practitioners rotated through all theatres so they had expertise in all types of surgery and could cover on emergency lists.

Ward daily nurse staffing were kept under review with the aim of getting the right staff in the right place at the right time. Safe staffing was reviewed twice daily in a meeting with senior oversight by a matron against a standard operating procedure for safe staffing. Results were sent to the director of nursing to review each day. Staff were moved in line with the acuity and dependency of patients on wards, and also considering the ratio of agency to substantive staff in ward areas, to ensure wards were safely staffed. Any additional requests for agency were escalated for review and assessment by the director of nursing or chief executive. Changes had been made to improve registered nurse to patient ratios to one to six/seven during the days and one to
eight/nine at night. Achieving these ratios had been challenging on occasions due to lack of staff and agency availability.

A six-month review was carried out nationally in June 2018, to help plan staffing. The following methodology was used:

- National Institute for Clinical and Healthcare Excellence (NICE) guidance
- Analysis of actual staffing.
- Acuity and dependency tool / Shelford Group Safer Nursing Care Tool (SNCT).
- Professional judgement.
- Workforce metrics
- Information on key nurse sensitive quality outcomes
- National Quality Board (NQB) guidance and Royal College of Nurses (RCN) guidance.
- Benchmark against partnership trust standard of one to six registered nurse to patients on days and one to eight at night for inpatient wards.

The trust has reported their staffing numbers below for March 2018 and November 2018:

<table>
<thead>
<tr>
<th>Ward</th>
<th>March 2018</th>
<th>November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>WTE Planned</td>
<td>WTE Actual</td>
</tr>
<tr>
<td>Day Case Unit</td>
<td>23.6</td>
<td>20.1</td>
</tr>
<tr>
<td>Hutton Ward</td>
<td>19.2</td>
<td>14.4</td>
</tr>
<tr>
<td>Main Theatres</td>
<td>33.0</td>
<td>26.4</td>
</tr>
<tr>
<td>Oncology Day Unit</td>
<td>4.5</td>
<td>5.1</td>
</tr>
<tr>
<td>Steepholm Ward</td>
<td>21.8</td>
<td>16.8</td>
</tr>
<tr>
<td>Waterside</td>
<td>11.4</td>
<td>9.8</td>
</tr>
<tr>
<td><strong>Grand total</strong></td>
<td><strong>113.5</strong></td>
<td><strong>92.6</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staff tab – update provided)

We were provided with updated main theatre staff data which showed there were 10.32 whole time equivalent posts vacant in main theatres, across different nursing staff grades.

Main theatres were not permitted to recruit to their vacant posts, despite interest, as theatres were not being fully utilised so full staffing was not always required. Permission had been provided for agency use if they required additional sessions. In the last four months October 2018 to January 2019 bank usage averaged 2.33 WTE monthly.

**Vacancy rates**

From December 2017 to November 2018, the trust reported a vacancy rate of 23.2% in surgery. This is higher than the trust target off 8% and the trust average of 15.7%.

Main theatres had the highest vacancy rate (44.1%), followed by Hutton Ward (23.7%) and
Waterside (22.1%).
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From December 2017 to November 2018, the trust reported a turnover rate of 13.3% in surgery. This is lower than the trust target of 15%.

The units with the highest turnover were Steepholm ward with 27.2%, main theatres, with 22.8%, and Waterside, with 11.6%.
(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

Sickness was managed by sisters with support from HR. From December 2017 to November 2018, the trust reported a sickness rate of 3.6% in surgery. This is lower than the trust target of 3.9%.

The units with the highest sickness rates were Waterside (14.1%), Day case unit (3.5%) and Steepholm ward (3.3%).
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and agency staff usage**

Agency staff were used in the day case unit at times of escalation to ensure there was safe staffing to care for the inpatients.

There was an induction for agency staff to ensure competency when using agency on the surgical wards. This investment of time often created more stress for the substantive team. Concerns were expressed about the quality of some agency staff who were not always equipped to perform at the required level of competency on the wards. We were told ward sisters liaised closely with the matron and the agency concerned if there were any concerns about competency.

From December 2017 to November 2018, the trust reported 5.5% of qualified nursing shifts in surgical care were filled by bank staff and 7.9% of shifts were filled by agency staff. In addition, 1.3% of shifts were not filled by bank and agency staff to cover staff absence.
(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

**Medical staffing**

The service did not always have enough medical staff with the right qualifications, with vacancies in some specialties. However, there was adequate medical staffing levels on the wards to safely meet the needs of patients.

The trust has reported their staffing numbers below for March 2018 and November 2018. Fill rate has decreased and there was nearly 2 WTE fewer in post in November 2018 compared to March 2018.

<table>
<thead>
<tr>
<th>Location</th>
<th>March 2018</th>
<th>November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned WTE</td>
<td>Actual WTE</td>
</tr>
<tr>
<td>Total</td>
<td>22.5</td>
<td>20.3</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)
Vacancy rates
From December 2017 to November 2018, the trust reported a vacancy rate of 14.3% in surgery. This is higher than the trust target of 8% but lower than the trust average of 15.7%.
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates
From December 2017 to November 2018, the trust reported a turnover rate of 7.4% in surgery. This is lower than the trust target of 15%.
(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates
From December 2017 to November 2018, the trust reported a sickness rate of 0.5% in surgery. This is lower than the trust target of 3.9%.
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage
From December 2017 to November 2018, the trust reported a bank usage rate of 3.5% and a locum usage rate of 2.4% in surgery. 0.9% of hours not filled by bank or locum staff.
(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

Staffing skill mix
In September 2018, the proportion of consultant staff reported to be working at the trust was similar to the England average. The proportion of junior (foundation year 1-2) staff was higher than the England average.

Staffing skill mix for the whole-time equivalent staff working at Weston Area Health NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>51%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>8%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>20%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>21%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty  
~ Registrar Group = Specialist Registrar (StR) 1-6  
* Junior = Foundation Year 1-2  
(Source: NHS Digital Workforce Statistics)
There were arrangements for consultant surgical presence. Consultants were available 8am to 8.30pm weekdays, and 8am to 2pm weekends on-site, and would attend if a review was required. A consultant was available by phone at all times and would call the senior house officer between 10pm and 11pm. For orthopaedics this differed slightly. Consultant orthopaedic presence was until 7pm on weekdays, with a phone call at 9pm to the on-call registrar. On call weeknight consultant attended the trauma handover meeting at 8.30am the next day and proceeded to do the post take ward round (reviewing new patients who had been admitted overnight), this occurred weekdays and weekends.

The orthopaedic team within the hospital were well received by the multidisciplinary team. There were eight orthopaedic consultants, with particular areas of expertise. Each consultant was also part of the emergency trauma rota. Junior staffing was provided by a mixture of deanery surgical trainees, fellows and trust doctors. The department was popular with trainees, the teaching was said to be good with plenty of opportunities in a rather less stressed environment than in a bigger trust. This was the view of the consultants and trainees we spoke with.

The clinical leads spoke of challenges in adequately staffing some of the departments, particularly in urology as there was not enough consultants to provide full consultant cover seven days a week. The urology team were working with a local hospital to provide emergency cover, mostly at weekends. The general surgeons on call at Weston General Hospital were expected to provide emergency cover with back up from the local hospital if required. However, most of the recently appointed general surgeons had not had significant amounts of training in urology and therefore didn’t feel able to offer significant help. This issue had been highlighted in a recent inspection by Health Education England. The urology department had discussions with colleagues from the local hospital to try and regularise the system of support, there had been some progress made with this.

Junior doctors were not confident the processes to support urology patients overnight and at weekends were functioning effectively. Talking to juniors, the process, although improving, was still quite variable depending on which individuals were on call for general surgery and the co-operation of the local hospital urologists to provide advice or facilitate patient transfers. We were told some urologists from the local hospital would not speak to a junior doctor and insisted a call from the consultant general surgeon.

There was limited review to be assured of the effectiveness of the urology support process. We requested a copy of the audit of urology patients at weekends. This was a basic audit and information was not analysed. The data included patient ID, admission date with time, and date and time first seen, with senior review by specialist registrar or consultant. There had been nine patients admitted at the weekend for urology between 23 March 2018 and 3 March 2019. The average time elapsed between admission and senior review was eight hours.

The anaesthetic team included 12 consultants, with a further consultant recruited. There were six consultant anaesthetists for general anaesthesia for theatre lists. There were nine juniors within the team. Over the weekend two consultants covered theatre and intensive care unit. There was a contingency plan should patients require transfer to other hospitals and around emergency theatre if additional support was required.

Allied Health Professional staffing
There was safe provision of physiotherapy and occupational therapy for patients following surgery. There was joint working between physiotherapy and occupational therapy giving comprehensive assessments of mobility and independence and medical fitness for discharge. Therapists worked flexibly to meet the individual needs of patients and with colleagues in the home teams and social workers.

There was rapid access to therapies on the wards. However, this could be compromised when there were staff shortages. Therapists attended the daily board rounds to discuss patient’s status and discharge planning. Therapists provided a weekend service with therapists generally working one weekend in every five weeks.

Other professionals supporting the care of patients on the ward included dieticians and the pharmacist team.

**Records**

**Staff kept detailed records of patients’ care and treatment.** Records were clear, up-to-date and easily available to all staff providing care. Records were held securely in surgical areas visited.

We reviewed 20 patient records either in theatre or on wards. All patient records we saw were well completed and reflected the needs of patients. We checked a range of information including the patient being seen by a consultant within 12 hours of admission, the diagnosis and management plan, evidence of daily ward round, observations, a review of antibiotics and input from the multidisciplinary team. We saw signatures were identified with name and General Medical Council numbers. Care pathways were well completed with evidence of pre-operative assessment for anaesthetic risk, VTE, nutrition, and MRSA screening documented. Consent forms were adequately completed with clear description of likely risk. Results were clearly visible and there was evidence patients were being reviewed daily.

**Patient records showed a multidisciplinary collaborative approach to care.** They were well written and managed in a way that kept people safe.

The availability of ward clerks on the wards meant patients notes were managed efficiently and effectively both during the patient stay or at the point of discharge.

The wards used electronic boards to give an overview of patient information. This gave staff the most up-to-date information at all times about their patients.

There was a focus on the delivery of discharge summaries with the aim no patient would go home without a summary.

**Medicines**

**The management of medicines could be improved to ensure best practice.** This included the storage and disposal of medicines, and medicines reconciliations.

We randomly sampled medicines in theatre rooms and recovery. On a check of medicines there were no expired medications, controlled drugs were well managed, and fridge temperatures were checked daily. However, in main theatres fluids were being stored in areas which were not locked.

Medicines were stored securely on wards in locked treatment rooms and were only accessible to authorised staff. Patients had individual lockers to store their medicines.

Fridge temperatures on wards were recorded daily to ensure medicines were kept at appropriate temperatures, however when temperatures were not in the recommended range there was not
always evidence action had been taken to address this. On both Steepholm and Hutton ward the nursing staff we spoke with, although regularly recording, they were not aware of the temperature in which fridges should be, and therefore when to identify and escalate any concerns. We found instances where temperatures were outside of the recommended range and there was no evidence of action taken.

Room temperatures were not being monitored. The medicines policy stated the ambient temperature for the storage of medicines should be monitored regularly and should not exceed 25 degrees. There were no assurance room temperatures were kept at this ambient temperature.

Opening dates were not always recorded on medicines which had a reduced shelf life once opened to ensure they were discarded within the required time range. We saw an example of this on Hutton ward.

We saw medicines reconciliation and clinical pharmacy screens were not always being completed. Medicine reconciliation was the process of ensuring that a hospital patient’s medication list is as up-to-date as possible. If incomplete it poses a risk that patients are not receiving the correct medication and doses while in hospital, or staff are not aware of adverse effects from medication. On Hutton ward we reviewed four patient prescription charts, all four did not have a completed medicine reconciliation, and only one had been screened by the pharmacist.

Medicines for discharge were being dispensed from the drug charts rather than waiting for the discharge summary to be produced.

To reduce the delays in discharge the ward had pre-packs of frequently used medicines available, however they had not been segregated from ward stock so there was risk they could be supplied without the relevant patient details.

There were appropriate arrangements for the recording of medicines administration and prescription charts showed medicines were being given as directed. We saw some medicines which had been dispensed for patients were being re-used instead of returned to pharmacy for disposal, this was not in line with the trust’s policy.

We reviewed ten prescription charts on Hutton ward and Steepholm ward. Every chart had allergies and sensitivities documented and all prescriptions were clearly and legibly written and signed. All nursing entries were signed for and any omitted drugs were identified with the appropriate code. All prescriptions were prescribed correctly and adhered to national guidelines and the British National Formulary.

Medication incidents were reported via the trust electronic reporting system. All medication incident investigations had pharmacy input. Staff said there was an open culture for reporting medicine incidents.

Staff had access to the hospital’s medicines management policy. This defined the policies and procedures to be followed for the management of medicines and included obtaining, recording, handling, using, safekeeping, dispensing, safe administration and disposal of medicines. Staff were knowledgeable about the policy and told us how medicines were ordered, recorded and stored.

The hospital had a controlled drugs policy, available on the intranet. A trained nurse signed all orders for controlled drugs (CDs) and all wastage was recorded in the ward CD register. CDs stock checks were completed in line with policy by two trained nurses, agency nurses were not allowed to check the CD stock.
We saw medication rounds on Hutton ward and saw how staff completing the round wore a red tabard, so people were aware they were completing this important job, to reduce disruptions to their medication round and increase safety with medication administration. We observed this to be effective.

All staff involved in the prescription, supply and administration of chemotherapy received appropriate competency-based training prior to undertaking these duties. There were clear guidelines on which staff members could perform activities related to chemotherapy. Guidance was available to support checking processes prior to administration, and this was followed by staff. There was regular monitoring of chemotherapy, to include checking blood parameters, renal and liver function and other relevant markers, to ensure the safety of patients.

All prescribing and monitoring of chemotherapy took place according to agreed and validated protocols. There were governance processes for situations where a clinician may need to prescribe outside these validated protocols. This process ensured prescribing was clinically appropriate and safe. Only suitably trained and accredited staff administered chemotherapy.

Risks were assessed from handling cytotoxic drugs for employees and anyone else affected by this type of work, and suitable precautions to protect them. There was a policy for dealing with cytotoxic waste and cytotoxic spillages. Cytotoxic waste was disposed of in purple bins. In clinical areas, prior to administration, chemotherapy was stored in a designated area, separate from other medicines due to their cytotoxic nature.

Patients were given appropriate information (both verbal and written) about chemotherapy. Including information on: the aim of treatment, the name of the medicines, the route the medicines will be given, the frequency of administration, the duration of treatment, potential side effects and action to take if these side effects occurred.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers were responsible for investigating incidents and sharing the learning. When things went wrong, staff apologised and gave patients honest information and suitable support.

We were provided with examples where incidents occurred, were identified and reported, and change was made with learning as a result. Staff told us they received feedback following incidents raised. An example was provided following a moving and handling incident and problems with slide sheets. This was discussed with the theatre team at their audit meeting.

Simulation and human factors training promoted learning from real incidents that had occurred.

There were systems to make sure incidents were reported and investigated appropriately. Staff were open, transparent and honest about reporting incidents and said they would have no hesitation in reporting incidents, and were clear about how they would report them.

All staff received training on incident reporting and understood their responsibilities to raise concerns, record safety incidents, and near misses.

The incident reporting policy set out the processes for reporting and managing incidents and described the root cause analysis investigation process and the roles and responsibilities of staff involved in the process.

All incidents were reported directly onto the incident reporting system which was available from all networked computers within the trust. This gave a single record of each incident, subsequent investigation, agreed learning, and evidence of the learning and its effectiveness.
Staff said they were encouraged to report incidents promptly and received feedback and shared learning.

One example related to an incident where patient observations were missed. Actions were taken to improve the frequency of observations and reviewed to ensure they were maintained. Learning was communicated on a one-to-one basis to the staff involved and cascaded to the wider team through the band six nurses, a newsletter and ward meetings.

Each speciality held a mortality and morbidity meeting to review and discuss specific incidents. Case studies were used to promote learning from mortality reviews.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From December 2017 to November 2018, the trust reported no incidents classified as never events for surgery.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported three serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from December 2017 to November 2018.

The incidents were slips/trips/falls meeting SI criteria, treatment delay meeting SI criteria, and surgical/invasive procedure incident meeting SI criteria.

(Source: Strategic Executive Information System (STEIS))

The trust shared with us root cause analysis reports and up to date action plans to demonstrate the learning from the incidents.

Duty of Candour

Staff showed an understanding of their responsibilities with the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Duty of candour was also covered in the mandatory training programme and the induction for new staff.

Duty of candour was included within all serious incident investigations and mortality reviews, root cause analysis and 72-hour report templates were live and included clear instructions for duty of candour and was reviewed on a weekly basis within the executive panel review for serious incidents.

The trust reported on duty of candour within the harm free trust board report, monthly integrated performance report and quality and safety committee papers.

Safety thermometer

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.
The service monitored the incidents of avoidable harm to patients from pressure ulcers, falls, catheter-associated urinary tract infections, and venous thromboembolisms and took part in the national safety thermometer performance.

There was a public display on the surgical wards, which showed how many avoidable patient harms had occurred in the previous month including the last incidence of MRSA and clostridium difficile, cleanliness scores, hand hygiene, the last pressure ulcer and the last fall with harm.

Staff said there were often problems in submitting safety thermometer data due to the intermittent wi-fi access. This meant information was not always captured and uploaded.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

**Safety thermometer data**

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed the trust reported three new pressure ulcers, no falls with harm and seven new catheter urinary tract infections from November 2017 to November 2018 for surgery.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Weston Area Health NHS Trust**

1 Pressure ulcers levels 2, 3 and 4
2 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital)

**Is the service effective?**

Evidence-based care and treatment
The service provided care and treatment based on national guidance and evidence of its effectiveness. They continually reviewed guidance to help improve services.

Policies, care and treatment pathways, and clinical protocols had been developed in line with national guidance. These included the National Institute for Health and Care Excellence (NICE). Policies were available to all staff via the trust intranet system and staff showed they knew how to access them.

Clinical leads informed us they were emailed updated or new guidelines and best practice and would check to see if they were relevant to their specialty, and if practice needs to be changed accordingly.

There was an annual audit plan which the clinical teams contributed to. This enabled the service to benchmark the standard of care provided at the trust against local and national standards. Teams were involved in a range of clinical audits and results were shared with colleagues. These include national audits, specialty audits, and audits of NICE guidelines.

There was a focus on national safety standards for invasive procedures (NatSSIPs) in line with the September 2015 NHS wide programme. Local safety standards were developed, for example for central lines and tracheostomy. Detailed checklists were used in combination with WHO forms. Examples of developed NatSSIPs included procedural verification and site marking, prosthesis verification procedure, and prevention of retained foreign objects.

The wards completed a web based app audit to collect information about the quality of care and to ensure continuous improvement and identify real time problems.

The sepsis screening tool had been redesigned in alignment with NICE and UK Sepsis guidance for inpatients. Staff were knowledgeable about and adhered to the Sepsis six protocol. The trust audited patients to ensure timely administration of antibiotics and appropriate escalation. Sepsis education was provided for all staff. Awareness campaigns were held throughout the year such as ‘12 days of sepsis’ and ‘sepsis sleigh’, introduction of a ‘Sepsis Star’ initiative, deteriorating patient and sepsis study days.

The trust used a national early warning score (NEWS 2), designed by the Royal College of Physicians, to standardise the assessment of acute illness severity in the NHS. The use of NEWS 2, introduced in the trust in September 2018, ensured timely response and assessment of acutely ill patients and a standardised approach across the trust. Training was rolled out to staff to ensure they were confident and competent with the application of NEWS 2.

Patient monitoring in theatres was in line with the Association of Anaesthetics of Great Britain and Ireland standards, to ensure patients were effectively monitored during anaesthesia and recovery.

In pre-operative assessment evidence based guidance was used to deliver effective care and treatment. We saw evidence of pre-operative assessment protocols being based on evidence based guidelines, some examples include: anti platelet therapy, MRSA protocol, and pre-operative assessment NICE guidelines.

The trust had implemented the neck of femur pathway and had shown positive outcomes through the hip fracture quality improvement project.

Enhanced recovery programmes were followed. For example, for colorectal patients there was a booklet for enhanced recovery ‘daily surgical review and discharge planning’.
A gap analysis was completed for the surgical pathway for infection control based on the association of perioperative practice and royal college of nursing guidelines. This goes to the infection prevention and control committee quarterly for review and to surgical governance.

Staff encouraged patients to be out of bed by 11am or their head positioned at 30 degrees if they remained in bed. The overall aim was to reduce mortality from hospital-acquired pneumonia by simple measures such as raising their heads, good mouth care and mobilisation.

**Nutrition and hydration**

**Staff gave patients enough food and drink to meet their needs and improve their health.** Special feeding and hydration techniques were used when necessary. Food and hydration charts were used and completed.

The assessment and response to patient’s nutritional and hydration needs were managed effectively. Patients were screened to identify those who were malnourished or at risk of becoming malnourished. The malnutrition universal screening tool (MUST) was used to assess and record patient’s nutrition and hydration risks on admission to hospital and weekly thereafter. We saw this had been completed in all records we looked at. Nursing staff told us a nutritional care plan would be created for patients with a high MUST score. Nurses also told us they could refer patients to the dietitians, including patients requiring artificial feeding via a tube and renal patients on dialysis.

Different dietary requirements were recognised such as for patients with diabetes and those who required a gluten free diet.

An orthopaedic dietetic assistant on Hutton ward gave individualised input to identify patients’ nutrition and hydration needs and an appropriate care support plan.

Dietetic assistant support was available to patients to help with achieving good nutrition. This included; choosing suitable menu options, giving additional nourishing snacks and drinks between meals, help adding extra nourishment to foods, and helping at meal times such as cutting up food and helping to feed if required.

**Pain relief**

**Staff assessed and monitored patients regularly to see if they were in pain.** Patients’ pain was managed effectively for patients who had the capacity to communicate effectively. Staff supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

The National Early Warning System for patient observations was used which included pain as a parameter. Patients we spoke with said their pain was managed well and they received prompt pain relief. We saw nurses ask patients whether they were in pain, administering pain relief if required and documenting pain scores in patients' notes. One patient undergoing orthopaedic surgery told us the process was well managed and they had been pain free throughout.

There was a lead specialist nurse for pain who assisted with chronic and acute pain and attended the wards regularly. They were responsible for; reviewing policies, practices and training, and supporting orthopaedic enhanced pathway for planned care, and the colorectal team and cancer patients. They supported patients pre and post operatively on a one-to-one basis as required and devised a patient pain management plan. They engaged with the multidisciplinary and had a key relationship with the physiotherapists. Staff told us they were contactable at any time for advice.
or to review a patient. A business case had been prepared to employ an additional member of the team.

**Patient outcomes**

The **effectiveness of care and treatment was monitored and findings used to improve services.** The results of national audits did not suggest any of the surgeons or the trust was a significant outlier.

Information about the outcomes of patients care and treatment were routinely collected and monitored. A number of regular audits were carried out to review and demonstrate the quality and safety of services delivered against national patient outcomes. These audits were monitored and action plans to address areas of improvement were regularly reviewed.

**National Hip Fractures**

**There had been efforts to improve clinical pathways for patients undergoing hip replacements and fractured neck of femur repair.** At our previous inspection we issued a requirement notice for the neck of femur pathway which required significant improvement. The trust had participated in the national hip quality improvement programme work, where they performed well, and had seen a reduction in mortality from fractured neck of femur to below the national average, and a reduction in overall length of stay for hip replacements. Patient Reported Outcome Measures (PROMs) in this area had also seen an improvement. There were plans to devise a policy with patient flow for neck of femur patients.

The integrated performance report presented data for the fractured neck of femur.

- The percentage of patients assessed by an orthogeriatrician within 72 hours of admission to emergency department or fall within hospital. From April 2018 to January 2019 performance averaged 89.25% which was just short of the 90% standard.
- Surgery within 36 hours of admission to emergency department or fall within hospital. From April 2018 to January 2019 performance averaged 85.51%.
- We requested data to show patients were admitted to an orthopaedic ward within four hours, this data was only captured up to May 2018. Thus, there was no assurance for performance against this.

**National Hip Fracture Database**

The data described below is the 2017 data, and therefore is not a reflection of where the trust was at the time of our inspection.

In the 2017 National Hip Fracture Database for Weston General Hospital, the risk-adjusted 30-day mortality rate was 7.0%, which was within the expected range. The 2016 figure was 10.7%.

The proportion of patients having surgery on the day of or day after admission was 76.9%, which failed to meet the national standard of 85%. This was within the middle 50% of trusts. The 2016 figure was 75.3%.

The crude perioperative medical assessment rate was 68.9%, which failed to meet the national standard of 100%. This was within the bottom 25% of trusts. The 2016 figure was 83.8%.

The proportion of patients not developing pressure ulcers was 93.1%, which failed to meet the national standard of 100%. This was within the bottom 25% of trusts. The 2016 figure was 98.1%.

The length of stay was 22 days, which falls within the middle 50% of trusts. The 2016 figure was
20.4 days.  
(Source: National Hip Fracture Database 2017)

Surgical Site Infections

**Surgical site infection was monitored and investigated.** A proforma was completed to investigate any surgical site infections, reviewing the care provided and identifying learning or issues.

We reviewed surgical site infection surveillance data from Public Health England which was reported in January 2019.

- For knee replacements there was one patient out of 133 (0.8%) who was readmitted with a surgical site infection between January 2018 and September 2018. This performance was slightly better when compared to results from all hospitals for a five-year period from October 2013 to September 2018 reporting 1.3%.
- For hip replacements one patient out of 175 (0.6%) post discharge confirmed a surgical site infection between January 2018 and September 2018. This performance was slightly better when compared to results from all hospitals for a five-year period from October 2013 to September 2018 reporting 0.9%.

We reviewed surgical site infection surveillance data from Public Health England which was reported in October 2018:

- For large bowel surgery there were 18 surgical site infections from 129 patients (14%), between July 2017 and June 2018. This was not too dissimilar to results from all hospitals for five-year period from July 2013 and June 2018 reporting 11.2%.

Monitoring was done through a multi-disciplinary surgical site infection group and through to the infection control committee. Monitoring of surgical site infection was led by the infection control nurses. Three categories were analysed for surgical site infection: hip replacements, knee replacements and large bowel surgery. Public Health England surveillance questionnaires were sent 30 days post operatively to patients. There was approximately a 70% response rate.

We discussed with the lead infection control nurse the change to process to reduce the number of surgical site infections, one example included how for elective surgery; nose and groin swabs were taken, this has now been introduced for emergency surgery. In August 2018 they had extended MSSA screening for elective joint replacements. The process for decolonising for MSSA positive patients had changed and occurred five days before surgery, this was started on the 4 February 2019, the pre-operative assessment team manage the decolonisation process and were able to prescribe from a patient group directive (a written instruction to allow administration of medication and treatment).

For large bowel operations there were small numbers so a few surgical site infections can see an impact. The infection control nurse in conjunction with consultant surgeons was looking at methods how to improve surgical site infections, for example change of surgical wound closure practice.

**There were difficulties identifying patients who were re-admitted with a surgical site infection,** there was no process to identify these patients unless an incident was reported which allowed investigation. For those incidents which were reported an infection control nurse and microbiologist would review and investigate, and would review at the mortality and morbidity meeting if required.

Relative risk of readmission trust level
From September 2017 to August 2018, all patients at the trust had a similar to expected risk of readmission for elective admissions when compared to England.

Of the top three specialties by number of admission:

- Urology patients at the trust had a lower relative risk of readmission for elective admissions when compared to England.
- Colorectal surgery patients at the trust had a lower relative risk of readmission for elective admissions when compared to England.
- Trauma and orthopaedics patients at the trust had a higher relative risk of readmission for elective admissions when compared to England.

**Elective Admissions – Trust Level**

![Bar chart showing elective admissions for the trust compared to England.](chart1)

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

All patients at the trust had a lower than expected relative risk of readmission for non-elective admissions when compared to England.

Of the top three specialties by number of admission:

- General surgery patients at the trust had a lower relative risk of readmission for non-elective admissions when compared to England.
- Trauma and orthopaedics patients at the trust had a higher relative risk of readmission for non-elective admissions when compared to England.
- Urology patients at the trust had a higher relative risk of readmission for non-elective admissions when compared to England.

**Non-Elective Admissions – Trust Level**

![Bar chart showing non-elective admissions for the trust compared to England.](chart2)

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

(Source: Hospital Episode Statistics - HES - Readmissions (01/09/2017 - 31/08/2018))
Bowel Cancer Audit

In the 2017 Bowel Cancer Audit for Weston Area Health NHS Trust, 70.7% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than expected. The 2016 figure was 63.3%.

The risk-adjusted 90-day post-operative mortality rate was 3.8% which was within the expected range. The 2016 figure was 3.5%.

The risk-adjusted 2-year post-operative mortality rate was 24.8% which was within the expected range. The 2016 figure was 40.1%.

The risk-adjusted 30-day unplanned readmission rate was 3.7% which was within the expected range. The 2016 figure was 10.3%.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 62.4% which was within the expected range. The 2016 figure was 57.9%.

(Source: National Bowel Cancer Audit)

Oesophago-Gastric Cancer National Audit

In the 2016 National Oesophago-Gastric Cancer Audit (NOGCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 11%. Patients diagnosed after an emergency admission are significantly less likely to be managed with curative intent. The audit recommends overall rates over 15% could warrant investigation. The 2015 figure was 13.9%.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 38.3%. This was similar to the national aggregate (calculation formed).

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres; the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.

(Source: National Oesophago-Gastric Cancer Audit 2016)

National Emergency Laparotomy Audit

The national Emergency Laparotomy audit awards three ratings for each indicator. Green ratings indicate performance of over 80%, amber ratings indicate performance between 50% and 80% and red ratings indicate performance under 50%.

In the 2016 National Emergency Laparotomy Audit (NELA), Weston General Hospital achieved an amber rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 92 cases.

The site achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 67 cases.

The site achieved a green rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 68 cases.

The site achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 54 cases.

The risk-adjusted 30-day mortality for the site was within the expected range based on 92 cases.
Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting they feel worse can be viewed on the left.

In 2016/17 the trust’s performance on groin hernias for EQ VAS did not worsen as much as the England average and for the EQ-5D index the trust did not worsen more than the England average and improved more than the England average.

For hip replacements, performance was about the same as the England average for the EQ-5D index and the Oxford hip score, although for EQ VAS the trust worsened more than the England average and did not improve as much as the England average.

For knee replacements performance was about the same as the England average.

(Source: NHS Digital)

Competent staff

The service made sure staff were competent for their roles. Staff had the right qualifications, skills, knowledge and experience to do their job when they started employment, took on new responsibilities, and on a continual basis.

There were competency frameworks and staff were aware of the requirements. We reviewed the training and development programme in theatres. Detailed training packs had been introduced which had resulted in more staff being competent in a wider range of specialties, meaning they were able to work across different specialty theatre lists as required. We also
reviewed comprehensive training packs for new starters which had been completed.

The arrangements for supporting and managing staff included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation. Most staff we spoke with were positive about the quality and the frequency of the clinical supervision they received.

Staff were encouraged and had opportunities to develop. Staff were encouraged to keep up-to-date with their continuing professional development and there were opportunities to attend external training and development. Most staff told us they had access to training. However, we were told it was on occasion difficult for staff to find time for training and development, or they could not be released from the ward because of a lack of staff.

The service undertook a range of education and practice development activities aimed at enhancing the knowledge, skills and awareness and development of the staff. There were study days including simulation training and speciality training.

There was a clinical supervision policy, guide and toolkit. A focus group had increased awareness and engagement with face-to-face education and information. Practice development nurses supported staff with accessing appropriate clinical supervision.

Clinical supervision for medical staff occurred at departmental meetings (including morbidity and mortality meetings), clinical governance and grand round teaching with minuted evidence of learning and actions. In part this was delivered through daily board rounds as part of the SAFER bundle (a tool to reduce delays for patients in adult inpatient wards) and daily senior presence.

Each junior doctor had both clinical supervisors and an educational supervisor. The postgraduate officer kept a record of the clinical supervisors. Clinical supervision activities were discussed at appraisal.

Consultant and middle grade doctors supported junior doctors. A positive teaching environment was observed. Junior doctors spoken with were happy with the support they received from senior colleagues, who were visible and approachable. An orthopaedic registrar told us they were happy with the training they received and there were plenty of opportunities, with a consultant body who was keen to teach.

There was a student nurse learning pack for clinical placement which included clinical and practical knowledge i.e. professional values, communication and interpersonal skills, nurse practice and decision making and learning outcomes.

The compliance with appraisals could be improved. Completed appraisals were not meeting trust targets. Managers appraised staff work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service. From December 2017 to November 2018, 78% of staff within urgent and surgery care at the trust received an appraisal compared to a trust target of 85%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required (YTD)</th>
<th>Appraisals complete (YTD)</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Qualified Scientific, Therapeutic, Technician Staff</td>
<td>6</td>
<td>5</td>
<td>83.3%</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>76</td>
<td>60</td>
<td>78.9%</td>
</tr>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>91</td>
<td>70</td>
<td>76.9%</td>
</tr>
</tbody>
</table>
Multidisciplinary working

Staff from different professions or departments worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. It was commented how it was a small hospital and therefore there was easy communication between specialties.

All necessary staff, including those in different teams and services, were involved in assessing patients' care and treatment. The patient records showed input from dieticians, physiotherapists and occupational therapists and therapy technicians. Records also showed input from pharmacists, medical teams, and diagnostic and screening services.

The theatre teams observed were well organised and knew their roles which were performed efficiently and competently. One consultant working in theatre told us “there is an efficient team, and they work amazingly”

Ward clerks supported the team with appointments, referrals and discharge. Ward clerk hours had been reviewed and improved cover was provided at weekends and evenings to help improve the infrastructure. Ward clerks were now full time on their surgical ward which helped ensure consistency and teamwork.

Staff worked together to assess and plan ongoing care and treatment in a prompt way when patients were due to move between teams or services. This included referral, discharge and transition. Staff were aware good multidisciplinary communication was central to safe patient transfers and could describe how they would do this. This included preparation and risk assessment.

Staff reported good multidisciplinary team working with meetings to discuss patient’s care and treatment. There was good team work across the disciplines with a focus of integrated care pathways. We saw a multidisciplinary meeting attended by a specialist lead for fractured hips, a ward sister, a consultant, physiotherapists, and a healthcare assistant to review practice for fractured neck of femur. Data was analysed including admissions against discharge, educational updates, best practice tariffs, overall performance, length of stay, delirium delays and social worker assessments. Plans were discussed to look at physiotherapy outcome measures and an assessment of the level of independence in the first three days following surgery and an assessment of residence, mobility and bone health 120 days post admission.

Seven-day services

The surgical division aimed to meet the seven-day service standards. They provided medical and nursing staffing, and the availability of diagnostic services.

There was 24-hour nursing, with senior nursing staff working after 5pm and over the weekends to offer support and guidance.

Medical cover was provided seven days a week, with different arrangements dependent on speciality. All emergency patients admitted were seen and had a thorough clinical assessment by a suitable consultant as soon as possible, but at the latest within 14 hours of arrival at hospital. We saw this evidenced in the patient records we reviewed.
Shift handovers were completed each day on surgical wards at 8am, with the consultant on call present. A further surgical handover was completed at 8pm between the day medical staff and night medical staff, with urology handover to surgery on a patient specific basis.

For orthopaedics on all days of the week at 8.30am consultants, registrars and senior house officers attended the trauma handover meeting. On Friday, Saturday and Sunday there was an 8pm handover between the day medical staff and night medical staff.

There was 24/7 inpatient access to consultant directed intervention for emergency general surgery. However, there was no dedicated surgical assessment unit, and the trust was using ambulatory emergency care.

There was provision to ensure the multidisciplinary review of all emergency inpatients was completed.

Therapy was available during the day and at weekends. The physiotherapy service ran from 8.30am to 4.30pm on weekdays. An on-call service for those patients requiring rehabilitation from orthopaedic conditions occurred on weekends.

There was access to all key diagnostic services 24 hours a day, seven days a week to support clinical decision making.

- 24/7 access to microbiology where tests were classified as urgent, with routine reporting during weekday working hours and a reduced service over the weekends.
- Cellular pathology provided a five-day service 9am to 5pm.
- Blood sciences was available 24/7 for urgent tests with a one-hour turnaround time for critical tests.
- 24/7 access to CT with reporting by onsite radiologist or external contract.
- 24/7 access to X-ray.
- MRI was available weekdays with onsite reporting.
- Ultrasound service was available weekdays and a service for gynaecology on Saturdays.

**Health promotion**

Health promotion was a routine part of all care provided to patients. All staff worked collaboratively to assess all aspects of general health and to give support and advice to promote healthy lifestyles. This was observed during inspection at pre-operative assessments, before and after surgery, during an inpatient stay and at discharge. For example, during a pre-operative assessment a patient was provided with leaflets to stop smoking and asked if they would like to be referred to stop smoking support.

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent. We spoke to nursing and medical staff who showed a good knowledge of consent, mental capacity act (MCA) and deprivation of liberty safeguards (DoLS), and knew how to access advice if required.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
Most staff were aware of consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Staff had attended mandatory training and knew what their responsibilities were and how to apply them within everyday practice when required. Throughout the inspection we saw staff explaining the assessment and consent process to patients / carers and any need to share information with other professionals such as GPs or residential homes.

We heard staff discussing the treatment and care options available to patients and their relatives. We looked at 18 medical records and saw consent documents were fully and clearly completed. Where patients had been consented for their operation in their outpatient appointment, the consultant confirmed the consent on the day of the operation. If consent had not already been completed this was completed on the day.

There was a policy relating to Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and staff were aware of their responsibilities. A full entry was made in the patient’s medical notes as soon as a DNACPR order was made.

Mental Capacity Act and Deprivation of Liberty training completion

Training for Mental Capacity Act (MCA) was not meeting trust targets. The trust reported, as of November 2018, MCA training was completed by 80.5% of staff in surgical care compared to the trust target of 90%.

Over the same period Deprivation of Liberty Safeguards training was completed by 79.3% of staff in within surgical care compared to the trust target of 90%.

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

**Is the service caring?**

**Compassionate care**

Staff cared for patients with compassion, dignity and respect. We observed patients being treated with care and respect throughout their patient pathway for the surgical service. During our inspection we saw excellent interactions between staff, patients and their relatives. Staff were open, friendly and approachable and interactions were very caring, respectful and compassionate. The staff were skilled in talking with and caring for patients. Care from the nursing, medical staff, therapy staff and support staff was delivered with kindness and patience. The atmosphere was calm and professional without losing warmth and reassurance.

Staff took the time to interact with patients and those close to them, in a respectful and considerate manner. For example, we saw healthcare staff checking on patients in a gentle, kind and dignified manner. They involved and encouraged both patients and relatives as partners in their own care.

The patients we spoke with were largely positive about the compassion and kindness of staff, and their dedication to giving good care. The comments we received included, “I can’t thank them enough”, “they’re all so kind and helpful and nothing is too much trouble”, “couldn’t praise the hospital and medical teams highly enough”. However, we received negative feedback from one patient about the care received and the attitude of one doctor. The patient was aware of how to make a complaint to enable them to formally raise their concerns and planned to do this. Another patient did raise how the wards could get noisy at night time, and sometimes call bells were not always answered in a timely way. However, during the inspection we saw staff answering call bells quickly.
Many patients had written cards to express their thanks. Comments included, “the team are wonderful”, “I am very grateful for all of your hard work and care” and another said, “I am very grateful for your kindness and support”.

We saw good attention from all staff to patient’s privacy and dignity. Curtains were drawn around bed spaces for intimate care or procedures and doors were closed in side rooms when necessary. Voices were lowered to avoid confidential or confidential information being overheard. All patients said their privacy and dignity was maintained.

**Friends and Family test performance**

The trust used the NHS friends and family test to find out if patients and their relatives would recommend their services to friends and family if they needed similar treatment or care.

The friends and family test response rate for surgery at Weston Area Health NHS Trust was 40%, which was better than the England average of 27% from September 2017 to September 2018.

A breakdown of response rate by site can be viewed below and the percentage of patients who would recommend the service.

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp Rate</th>
<th>Percentage recommended</th>
<th>Annual perf</th>
</tr>
</thead>
<tbody>
<tr>
<td>Watterside</td>
<td>623</td>
<td>54%</td>
<td>Aug-17: 98% Oct-17: 100% Nov-17: 100% Dec-17: 92% Jan-18: 91% Feb-18: 100% Mar-18: 94% Apr-18: 95% May-18: 96% Jun-18: 97% Jul-18: 96%</td>
<td></td>
</tr>
<tr>
<td>Hutton</td>
<td>163</td>
<td>26%</td>
<td>Aug-17: 78% Oct-17: 100% Nov-17: 100% Dec-17: 62% Jan-18: 97% Feb-18: 92% Mar-18: 95% Apr-18: 84% May-18: 88% Jun-18: 100% Jul-18: 91%</td>
<td></td>
</tr>
</tbody>
</table>

Key: Highest score to lowest score

- The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above), as well as wards where there were less than 100 responses in total over the 12-month period.
- Sorted by total response.
- The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

**Emotional support**

**Staff provided emotional support to patients to minimise their distress.** Staff understood the impact the care, treatment or condition might have on the patient’s wellbeing and on those close to them both emotionally and socially. Staff talked about patients compassionately and with knowledge of their circumstances and those of their families.

We observed friendly environments in the anaesthetic room prior to the patient being anaesthetised. Staff provided support to the patients, whether it was to hold their hand, a hand on a shoulder or talking to them as a method of distraction, this helped patients relax at an anxious time.

We saw staff giving emotional support to patients and their relatives during their visit to the wards. Patient’s individual concerns were promptly identified and responded to in a positive and reassuring way. One patient told us the “staff always seem to know when I need reassurance ... they’re absolutely fantastic.”
Patients were spoken with in an unhurried manner and staff checked if information was understood. Difficult information was discussed in a sensitive manner and a relative told us how supportive the entire team had been “they’ve helped me get through the shock of things ... I don’t know where I’d be without them.”

Staff supported patients with mental health needs who became distressed in an open environment, and helped them to maintain their privacy and dignity.

There was good support from the hospital multi-faith chaplaincy team who were on call at all times for patients and their family and friends.

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

**Staff involved patients and those close to them in decisions about their care and treatment.** We saw staff explaining things to patients in a way they could understand. The patients spoken with felt well informed as to their diagnosis and care plans, they felt their management was being discussed with them as much as possible.

Patients were provided with a detailed account of what would happen during their surgery during their pre-operative assessment. On the day of surgery patients were informed again of the process. Through each stage of the process explanations were given to the patient and verbal consent obtained.

We observed good involvement of the patient when being handed over from the recovery area to the ward.

Patients were involved with their care and decisions taken and said all procedures had been explained and they felt included in the treatment plan and were well informed. This included the consultant explaining the surgery events in detail and nurses talking through information leaflets.

We saw a ward round, where the patient was the focus and included in discussions and asked for their opinion about the treatment plan and if they had any questions.

We saw a couple of therapy sessions. The patient’s relative had been invited to attend the session to encourage the patient to walk. There was a flexible and patient-centred approach to the delivery of therapy.

We spoke with one patient who was on the cancer pathway. They felt their care and treatment had been explained to them clearly throughout, and they would be visited by a cancer nurse following their treatment to help support them and further explain.

Staff showed understanding and a non-judgmental attitude when caring for or talking about patients with mental health needs or learning disabilities.

Staff had access to communication aids via the learning disabilities team to help patients become partners in their care and treatment.

Staff made sure patients knew who the staff were and what they did. All healthcare professionals involved with the patient’s care introduced themselves and explained their roles and responsibilities.

Staff understood and respected the personal, cultural, social and religious needs of people and how these could relate to care needs.

**Is the service responsive?**

**Service delivery to meet the needs of local people**
The trust tried to plan and provide services in a way that met the needs of local people, however they were restricted by the uncertainty of the future for the surgical service and the whole trust. As recognised by staff, the main difficulties facing the trust were the impending reorganisation of services and the uncertainties which implicated on local planning. Some specialties were too small to be able to function independently, and a number of service redevelopments had happened or were in the pipeline. This was having a negative effect on staff morale and retention in some areas of the trust.

Theatre productivity was a priority for the transformation team. Phase one required an overview of what the theatre team had done so far, and this was due to be presented by the theatre matron to the theatre transformation team on 18 March 2019 following our inspection. The transformation team and theatre matron were in the process of validating findings and identifying tangible workstreams to enable improvement. Peer support from the local acute trust was being sought.

There was a winter plan to support the hospital through the winter period, defined as beginning of November 2018 through to end of March 2019. This outlined the plan and actions to help the trust be resilient during times of pressure. Emergency bed capacity within the surgical areas, following the escalation plan, included; day case unit (16 medical beds), Waterside side rooms (four additional beds), Ashcombe ward (five-day case beds), and oncology day case unit (six bed).

The day surgery unit was used for inpatients at times of escalation. The environment in the day surgery unit was not ideal for patients. It did not contain appropriate facilities for showering, impacting on the dignity for patients. Patients would be taken to an inpatient ward for showering. There was a clear criterion for patients who were suitable for being cared for as inpatients on the day surgery unit. During our inspection we saw patients had access to hot food and drinks when inpatients in day surgery unit. The theatre sister told us feedback from patients had mostly been positive and there had been no complaints. There were plans to consider addressing the environment.

The theatre receiving unit was limited by its environment, reducing the ability to make the unit’s environment appealing and meeting the needs of individuals. However, was being managed as best it could by the team. The waiting room, where patients waited prior to the surgery was previously one room for males and females. This had been changed by utilising additional space so a designated male and female room could be allocated. One room was more welcoming with a television and a more inviting atmosphere. The second room was an old clinic room and did not have a television. As discussed previously, the theatre receiving unit was combined with the pre-operative assessment unit.

The surgical assessment unit was closed in December 2018. This reduced the number of surgical bed space, although added capacity for the medical bed space for the hospital. Surgical ambulatory patients referred from their GP or from the emergency department would go through the ambulatory emergency care, at weekends this was run through the surgical outpatients.

The surgical wards have improved their infrastructure since October 2018, with ward clerks working with a ward rather than a central team, and 11-12 hours cover being provided daily. This had been advantageous for the ward running.

There was collaborative working with the local ambulance trust. When the emergency department was closed overnight the paramedics were able to triage and assess patients for a fractured neck of femur. Those patients were still transferred to Weston General Hospital via the medical assessment unit. These patients could then be treated in a timely manner.
The orthopaedic department had a locum orthogeriatrician in post to improve the management of elderly patients undergoing orthopaedic surgery. This had improved since our last inspection where we had issued a requirement notice as there was no orthogeriatrician in post. Improvements were identified with the fractured neck of femur pathway. Please see patient outcome section in the effective domain for the detail of this improvement.

Meeting people’s individual needs

The service took account of patients’ individual needs. Patients were treated as individuals with treatment and care being offered in a flexible way and tailored to meet their individual needs.

The trust provided a framework to support communication with patients and carers who were non-English speakers, people for whom English was a second language, people with hearing or visual impairment, or who had learning disabilities. Staff were knowledgeable about this framework. The policy set out clear standards to promote good practice and covered the use of face-to-face interpretation, telephone interpreting, and written translation services. Interpreters were available and could be arranged prior to a patient visit if known.

There were arrangements for caring for patients with mental health, dementia or learning disability. There were flags on the electronic board system to alert staff there were additional needs for these patients, to enable this to be considered when providing care and treatment.

Patients were assessed for dementia using biological and social assessment and recognised tools. Wards were using the ‘this is me’ pathway for those patients living with dementia. Patients were assessed in the same way as any other patient for their acute health needs to ensure they received equitable care and treatment. Where necessary reasonable adjustments were made to help facilitate these assessments for example quieter spaces, supported by carers or the learning disability nurses. The trust had worked with Dementia UK to jointly fund an Admiral Dementia Nurse and was developing and supporting dementia care initiatives across the trust.

For patients living with a learning disability a proforma was used addressing and capturing reasonable adjustments, medication checks, unmet needs, resuscitation status, Mental Capacity Act, end of life status and general review. There were easy read department booklets and pictorial menus. Communication books were being developed to help with learning disabilities, any cognitive impairment, non-English speaking patients and the hard of hearing.

There were arrangements to support patients living with a learning disability who would be coming to theatres. We spoke with a learning disability champion for the day case unit who was passionate about their role. They were able to explain how the day case unit adapted to meeting a patient’s individual needs, for example relatives or carers supporting the patient and being present in the anaesthetic room or in the theatre if required. Consideration was given to patients being able to be placed first on the list where possible to ensure minimal disruption and anxiety.

We were shown a booklet which was provided to patients living with a learning disability who were due to attend the hospital for their surgery. This booklet was designed in collaboration with parents, community provider and staff, and was a photographic journey of what to expect. The learning disability champion attended quarterly learning disability steering group meetings.

The pre-operative assessment team held a ‘fit for surgery’ spreadsheet which highlighted any special requirements. This could be used for the access team when booking the patient. For example: if an interpreter was required, if a patient was bariatric and therefore needed additional equipment, or if a patient was particularly anxious.
The service also had appropriate discharge arrangements for patients with complex health and social care needs. Staff ensured the onward care team supported them to plan the discharge of patients with complex needs.

Clinical, therapy teams and social workers were involved in getting patients home safely. For those patients needing a longer period of rehabilitation this might be provided at home or in the community.

The chaplaincy department provided pastoral, spiritual and religious support for patients, families and staff. They provided support for all faiths (and none) and kept close contact with faith leaders in the community. There were chaplains giving a 24-hour emergency on-call service and lay volunteers. There were trust procedures for emergency marriages in hospital.

There were regular activities on the surgical wards including weekly tea parties, exercise and activity sessions, games, bingo and quizzes. Space was limited on the wards but staff were keen to create a designated area by moving beds when appropriate.

Peoples individual needs were considered with regards to food and drink provided, and support needed with eating and drinking. Snacks and hot and cold drinks were available for patients in addition to the regular breakfast, lunch and evening meal. There was also a 24-hour service to meet patients’ needs at other times of the day or night. The service made adjustments for patients’ religious, cultural and other preferences. Additional menus were available for example: snack and nourishing drinks menu, finger food menu, texture modified menus and low residue menu. There was a protected mealtime policy and this practice was encouraged in ward areas.
We saw housekeeping staff making sure patients received the appropriate food on the appropriate coloured trays to identify which patients required a special diet or assistance with eating their meals.

**Access and flow**

**People could access the service when they needed it.** Performance for referral to treatment times was generally in line with the national average. Cancellation of procedures tended to be due to times of escalation across the hospital which restricted the available bed space post-surgery. The utilisation of theatres was being reviewed and could be improved.

There were no patients waiting over 52 weeks from referral to treatment in the last year, between January 2018 and January 2019. The standard was zero tolerance to patients waiting over 52 weeks and the trust was achieving this.

**Elective Surgery**

Patients undergoing elective surgical procedures were referred for surgery from their outpatient appointment. All patients were seen pre-operatively, predominantly a nurse led pre-operative clinic, consultant led for orthopaedic surgery and some patients in other specialties, and referred to the anaesthetist pre-operative clinic if the patient was deemed higher risk. The anaesthetist led clinics had just been changed from once every two weeks to once weekly at the time of our inspection to improve access. Once patients were identified as fit for surgery their surgery date was arranged by the access team.

The access team would confirm an appropriate date for the surgery with the patient over the phone, based on current waiting list chronology, the priority and risk for each individual patient, and the session availability. A letter was sent to each patient confirming date of surgery, time of arrival, fasting instructions and any requirements for their surgery for example to shower and shave the surgical site. No further reminder would be provided to the patient.
On the day of surgery patients arrived in the day surgery unit (for day surgery theatres) or the theatre receiving unit (for main theatres) at 7.30am or at midday. Following their surgery patients would be transferred to one of the three surgical wards for inpatient care or to the day surgery unit if they were to be discharged the same day.

**Emergency Surgery**

There was capacity for emergency surgery. This was provided throughout the week, out of hours and at weekends. There was an emergency team available for this cover.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

The trust has sustained their referral to treatment time (RTT) performance. From December 2017 to November 2018 the trust’s RTT for admitted pathways for surgery was about the same as the England average. A capacity meeting was held weekly to review any patients over 35 weeks, 18 weeks and 16 weeks, and review capacity.

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) – by specialty**

One specialty was above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>63.9%</td>
<td>59.3%</td>
</tr>
</tbody>
</table>

Two specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>75.9%</td>
<td>76.5%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>60.1%</td>
<td>72.2%</td>
</tr>
</tbody>
</table>

**Theatre Scheduling**

A theatre scheduling meeting was held weekly to review the list and lock it down. There was a look back and learn, to review any errors for improvement from the previous week.

If the theatre list changed there was a clear process to update the list and a different colour print out of the list was provided so all staff knew they had the correct updated version.

The schedule was reviewed six weeks ahead. The session was locked down four weeks before.

If a patient needed to be added 24 hours before, an email was sent to obtain permission and sign
The theatres were not being fully utilised as there were not enough surgeons to run theatre lists. This was included on the surgical risk register and there were plans to increase theatre utilisation as part of theatre transformation, however this was in its infancy. We were informed the plan for March and April 2019 showed improved theatre utilisation. Surgeon job planning required review to ensure full utilisation of theatres could be achieved, at the time of our inspection we were aware this was being reviewed with the surgeons.

Theatre monthly utilisation was reported reviewing the utilisation of elective sessions, in session utilisation, late starts, cancellations, and number of procedures. There were comments and key actions included within this report and some data was broken down to review reasons.

The integrated performance report presented data for theatre performance to the board. Between April 2018 and January 2019, this showed:

- Late starts to elective theatre was at 42.6%, which was worse when compared to a 9% target.
- Theatre session utilisation was at 75%, which was worse when compared to an 85% target.
- Theatre in session utilisation was at 83.6% which was not too dissimilar to an 85% target.

**Theatre productivity was now being reviewed on a regular basis and guiding the theatre transformation project.** A theatre productivity update report was made available weekly. We reviewed a report for the week commencing 18th February for 272 day case and 21 elective inpatient procedures.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Trust Target</th>
<th>Actual</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session Utilisation</td>
<td>85%</td>
<td>69%</td>
<td>Improvement from previous week.</td>
</tr>
<tr>
<td>In Session Utilisation</td>
<td>85%</td>
<td>87%</td>
<td>Improvement from previous week.</td>
</tr>
<tr>
<td>Late start % against available minutes</td>
<td>&lt; 5%</td>
<td>2.6%</td>
<td>Improvement from previous week. Ten lists started late with average 16 minutes delay, which equates to 163 minutes operating time lost. Reasons included surgeon late arriving (six cases), equipment issue/failure (two cases), escalation late decision (one case) and anaesthetist late arriving (one case).</td>
</tr>
<tr>
<td>Average case per list</td>
<td>Not set</td>
<td>2.75</td>
<td>Main theatre two per list, day case unit 3.5 per list.</td>
</tr>
<tr>
<td>On the day cancellation for non-clinical reason</td>
<td>0.8%</td>
<td>0%</td>
<td>Seven planned surgeries cancelled on the day compared to 13 in previous week. All seven were due to clinical or patient related cancellations.</td>
</tr>
</tbody>
</table>
There were concerns raised in the board papers and surgical governance with regards to late starts to theatre. This meant patients had been kept waiting for the theatre list to start. We discussed this with the teams and they informed us this was improving. Discussing with the medical team they had only recently been made aware of the data identifying late starts being attributable to surgeons being late. At the time of our inspection they had not been given the opportunity to explain the data. Consideration needed to be given to the reason surgeons were late, or if the reason for the late starts was being correctly recorded. The clinical leads were not aware of performance concerns with the surgeons with regards to late starts to theatres and were planning to review this in more detail.

Late starts to theatre lists were because of surgeons being late to theatres and bed availability not being confirmed until after the bed meeting. For example, in January 2019 from 54 late starts, nearly half at 25 were recorded as being due to the surgeon late arriving. Information wasn’t clearly captured as for the reasons clinicians were late starting. We were told by staff the main cause was due to escalation and therefore surgeons seeing patients across the hospital taking additional time.

During our inspection there were examples where theatre lists did not start on time. Although these were managed on the day, they could have been avoided, and would prevent a patient waiting for their surgery or delays in the theatre list.

On our first day of inspection one-day theatre list started late as the correct equipment was not identified until the patient was seen in the morning, this was because of the patient’s change to their wait since they were last seen by the consultant, and an admin error pre-operatively. This delayed the list by approximately 45 minutes. Because there was only one patient on the theatre list for that day there was no alternative to swapping the patient order, and priority was rightly given to the safety of the patient and therefore they were not taken to theatre until equipment was available. We were told this was not a regular occurrence. The theatre sister immediately investigated the cause for this error and would report as an incident. The patient was kept informed and an apology was given for the delay.

On our second day of inspection one patient was delayed until midday due to kit not being available, as the kit required was being repaired. The pre-operative assessment team checked whether the patient could drink due to the delay. The order of patients on the theatre list was changed so the whole list was not delayed.

Delayed discharge from recovery

No patients should wait over 60 minutes to be discharged from recovery to ward, however between September 2018 and February 2019 this key performance indicator was never met. This meant patients were waiting unnecessarily in recovery, while waiting for a bed to become available. Patients who stay in recovery once they are fit for discharge was captured on the governance report monthly and staff were encouraged to incident report this. Delayed discharges from main theatres recovery to wards was benchmarked against key performance indicators for 0% over 60 minutes and 10% over 30 minutes. Between September 2018 and February 2019, the KPI for over 60 minutes was never met, and the KPI for over 30 minutes was not met twice. During our inspection we identified a 50-minute wait for the nurse from the ward to collect the patient in main theatres recovery.

We were informed by the surgical leadership team an audit was completed reviewing delays in being discharged from recovery, however when talking to staff in recovery we were concerned they were not aware of this audit. Staff provided us with a historic audit dated May 2017 to June 2017 where data was collected for a five-week period reviewing retrieving and handing over a
patient’s care between recovery and the ward. There was a lack of conclusion and actions identified from this piece of work. We requested from the trust the current audit data, this showed data was captured with regards to numbers and performance but there was no evidence of it being reviewed and analysed for reasons for delayed discharge.

Cancelled operations

There was a trust standard operating procedure setting out strict guidelines for the cancellation of elective surgery. This outlines how the trust was committed not to cancel surgery, however if it was necessary, to follow protocol to enable prioritisation of operating lists and communication of decisions to reduce the impact to a minimum.

Surgery for cancer was only cancelled when necessary, and with sign of from an executive. The use of additional space in Ashcombe for the day surgery unit to use had helped protect cancer patient theatre lists. Staff told us it was very unlikely cancer patients would be cancelled, and there was a culture to protect these lists.

The integrated performance report presented data for cancellation of elective care operations, between April 2018 and January 2019 2.92% of operations had been cancelled, which ranged from eight to 20 cancellations in a month. The majority of the time these patients were rebooked within 28 days. There were no urgent operations cancelled for a second time.

Cancellation data only allowed reporting of cancellations on the day to be captured, not the day before. The surgical leadership team told us they were looking at the reporting system on cancellations to help better understand reasons for cancellation and enable audit. We reviewed the reasons for on the day cancellations for a six-month period between August 2018 and January 2019. The reasons were variable, for example patient did not attend, patient unfit for surgery, emergency/trauma took priority, ward beds not available and equipment failure.

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

Over the two-year period, the percentage of cancelled operations at the trust has fluctuated around the England average. It has followed a trend of 0% one quarter and then between 10%-15% the following quarter.

Percentage of patients whose operation was cancelled and were not treated within 28 days - Weston Area Health NHS Trust

![Graph showing percentage of cancelled operations over time]

Cancelled Operations as a percentage of elective admissions - Weston Area Health NHS Trust
Over the two years, the percentage of cancelled operations at the trust has been lower and thus better than the England average since April 2017. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

Day Surgery Unit

Additional bed capacity had been arranged to support the day surgery unit at times of escalation. This was because of the previous year cancellations when beds were not available. This involved use of an area on Ashcombe ward (maternity ward) which was adjacent to day case theatres. The room was four bedded with one side room. It required staffing to be arranged from the day surgery unit, normally provided by agency staff. This helped to prevent cancellations of patient surgery and protect patients with cancer having their surgery cancelled.

There were plans to use these beds during our inspection so not to breach mixed sex. There were 14 female patients due to go to theatre, but only nine spaces on the female side of the day surgery unit. We were told there was no system to alert female and male numbers when booking patients, and regularly on a Wednesday there was a breast and gynaecology list which meant a higher number of females attending.

Patient flow

The leadership team, for example theatre matron and ward matrons were well involved in flow and had a good awareness of the trust's position. There were meetings each morning at 8.15am between the surgical matron, theatre managers and ward sisters prior to the trust bed meeting to discuss theatre lists staffing, bed mapping, discharges in the theatres, wards and day case unit.

Bed management meetings took place every weekday at 8.30am, 12.30pm and 4.30pm. The meetings were attended by the manager on call, matrons, ward sisters and the site team to identity where there were safety issues, infection control issues, staff shortages, outlying patients, planned discharges and how these could be managed. We attended a bed management meeting.

We also attended a trauma meeting to discuss individual patients. Each patient was discussed in detail to ensure the team were fully briefed on their needs, and any impact this may have on patient flow.

Surgical inpatients

During our inspection there were urology inpatients in the day case surgery unit. These patients were reviewed promptly in the morning by the medical team. We observed the team reviewing the patients at 8am in the morning.

Average length of stay
Trust Level – elective patients

From October 2017 to September 2018, the average length of stay for all elective patients at the trust was 4.1 days, which is similar to the England average of 3.9 days.

Of the top three specialties by number of admissions, length of stay for:

- Trauma and orthopaedics elective patients at the trust was 5.0 days, higher than the England average of 3.8 days.
- Urology elective patients at the trust was 1.8 days, lower than the England average of 2.5 days.
- Colorectal surgery elective patients at the trust was 6.6 days, lower than the England average of 7.1 days.

Elective Average Length of Stay – Trust Level

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

Trust Level – non-elective patients

The average length of stay for all non-elective patients at the trust was 5.7 days, higher than the England average of 4.8 days.

Of the top three specialties by number of admissions, the average length of stay for:

- General surgery non-elective patients at the trust was 3.5 days, similar to the England average of 3.7 days.
- Trauma and orthopaedics non-elective patients at the trust was 10.6 days, higher than the England average of 8.6 days.
- Urology non-elective patients at the trust was 5.8 days, higher than the England average of 2.7 days.

Non-Elective Average Length of Stay – Trust Level

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

(Source: Hospital Episode Statistics)
Discharge

The discharge coordinator and the ward sister organised and co-ordinated discharges. These were discussed at daily board round meetings with the multidisciplinary team. The board round looked at the current bed status, an assessment of medical fitness, rehabilitation status, cognitive status, discharge requirements and home status. These were well structured and managed by the ward sister with physiotherapists, doctors and discharge coordinator in attendance.

Discharge information was communicated electronically to the patient’s GP so they were aware of the continuation of care required in the community.

Patients were telephoned the next day in line with best practice and patients could contact the wards following discharge if they had any concerns.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. There were policies and processes to appropriately investigate, monitor and evaluate patient’s complaints. We heard of examples where learning from complaints had helped improve the service.

Staff were encouraged to try and resolve concerns as they arose. The staff we spoke with were all aware of the trust complaints system and the service provided by the hospital’s patient advice and liaison service and complaints team. Staff were able to explain what they would do when concerns were raised by patients or their relatives. They said they would always try to resolve any concerns as soon as they were raised, but should the patient remain unhappy, they would be directed to the clinical manager or the trust complaints’ process.

Patients knew how to make a complaint if they needed to and felt they could raise concerns with the clinical staff they met. Most patients told us if any issues arose they would talk to the senior nurse available.

Information about making complaints was available in all surgical areas we visited. ‘A Guide to Giving Feedback or Making a Complaint’ leaflets were available on all wards and information could be accessed on the trust website with details about how to resolve concerns quickly and how to make a complaint. The leaflet was also available for people who required the information in other formats and font sizes. Interpreters or signers were available for those requiring access. Complaints could be made in person, by telephone, email, or letter.

Summary of complaints

From December 2017 to November 2018 there were 33 complaints about surgical care. The trust took an average of 36 days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be closed within 40 working days.

A breakdown of complaint by subject can be seen below:

<table>
<thead>
<tr>
<th>Subject of complaint</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>All aspects of clinical treatment</td>
<td>15</td>
</tr>
<tr>
<td>Patient Care</td>
<td>6</td>
</tr>
<tr>
<td>Appointments, delay/cancellation (in-patient)</td>
<td>3</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to</td>
<td>2</td>
</tr>
<tr>
<td>absence of care package</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Attitude of staff</td>
<td>2</td>
</tr>
<tr>
<td>Appointments, delay/cancellation</td>
<td>1</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>1</td>
</tr>
<tr>
<td>Consent</td>
<td>1</td>
</tr>
<tr>
<td>Admission, discharge and transfer arrangements</td>
<td>1</td>
</tr>
<tr>
<td>Appointments, delay/cancellation (out-patient)</td>
<td>1</td>
</tr>
</tbody>
</table>

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

Number of compliments made to the trust

From December 2017 to November 2018 there were 175 compliments within surgery. The top three wards for compliments were Waterside (52), Oncology (51) and Hutton (45).

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

Is the service well-led?

Leadership

The surgical leadership team were clear about their roles and understood the challenges faced by the service. The surgical leadership team included a general manager, associate medical director, and associate director of nursing. Each speciality had a management lead, nurse lead and clinical lead.

There was instability with the leadership due to frequent changes and interim arrangements. The general manager was in an interim position and was due to leave this post shortly after our inspection. Numerous staff commented on the changes to the management team and how although each change brought new ideas it did not enable consistency, and sometimes reinvented the wheel.

In theatres staff spoke of being well supported by the theatre management team which was strong, supportive and approachable, in particular the theatre matron provided good leadership.

The matron and ward sisters were an experienced and strong team with a commitment to the patients who used the service, and to their staff and each other. They carried out a wide remit of roles and responsibilities. A number of people had multiple roles within the hospital, which sometimes meant they were stretched to deliver in all areas.

Leaders were visible and available to staff, and we saw and heard about good support for all members of the team. Staff felt able to openly discuss issues and concerns and believed they would be listened to, and actions taken when necessary if anything needed to change or be addressed.

We received consistently positive feedback from staff who had a high regard and respect for their managers. One member of staff told us their manager “was always out and about… and always able to come up with an answer.” Another described their manager as “very loyal and will bend over backwards to help.”
Managers encouraged learning and a culture of openness and transparency. They had an awareness staff needed different leadership styles and were flexible in their approach to the needs of their teams.

Vision and strategy

The trust had a vision and strategy, however this was implicated by the trust future. The vision was reliant on the outcome of the consultation reviewing the future services at Weston General Hospital and planned merger with a local acute trust. Furthermore, the review of work of the sustainability and transformation plan. With a strategy of growth for surgical services at Weston General Hospital for elective surgery, and being clinically effective.

The strategy included the reprofiling of services to start in April 2019. Work on reprofiling had already started in orthopaedics. There were also plans to review of the theatre receiving unit, and a day case refurbishment to help with flow.

A theatre improvement board was reviewing the issues in theatres with an aim to make improvements in efficiency.

The surgical directorate vision was for a safe, quality, resources, caring, effective, morale, delivery.

The surgical directorate operational plan set out the objectives for two years for 2017 to 2019. This included the trust wide, surgical directorate, and speciality objectives. We could see progress had been made against the objectives to help improve the service provided.

The trust values were visibly displayed across the wards on information boards. They were: people and partnership, reputation, innovation, dignity and excellence (PRIDE).

Culture

There was a positive culture which supported and valued staff. Staff were positive about working for the trust, although there had been times when they felt stretched and under pressure because of the volume of their work, particularly during the pressures of last winter.

It was clear during our inspection all staff had the patient at the centre of everything they did. They were dedicated to their roles and approached their work with flexibility.

We were told by consultants how Weston General Hospital was a pleasant place to work as its size meant working relationships between staff and departments were good.

The staff we spoke with during the inspection said they were proud to work on the wards and in theatres and were passionate about the care they provided. The matron and sisters said they were proud of the staff they supervised. They said there was a high level of commitment to giving quality services for patients. One member of staff told us, “we are like a family and do the best we can,” another said, “we stick together when things get tough.”

Staff said they were encouraged to raise concerns and felt comfortable about raising any concerns with their line manager. Staff told us they were not frightened or worried to talk to their managers if something had not gone as planned

Staff were aware of the trust whistleblowing policy and the arrangements for reporting poor practice without fear of reprisal. They felt confident about using this process if required and concerns would be taken seriously.

Staff were also aware they could raise concerns about patient care and safety, or any other anxieties they had with the Freedom to Speak Up Guardian or ambassadors.
Governance

The trust used a systematic approach to continually improve the quality of its services and safeguard high standards of care.

The surgical directorate governance structure with the surgical directorate board meeting fed into the quality and safety committee. At a local level operational meetings and specialty meeting were held, which informed surgical governance and risk.

The directorates had been recently changed which meant there were 21 specialities and specialist areas reporting to the surgical directorate. Time was needed to see how the governance systems functioned effectively with a large number of services reporting to the surgical directorate board.

We reviewed three meeting minutes for the monthly surgical directorate governance meeting. Each department or specialty presented a governance report to this forum, along with relevant monitoring and assurance reports. We also saw examples of specialty or specialist areas reports being sent for review and sign off at the surgical directorate board, these reports identified main areas of governance to manage and monitor risk, issues and performance.

There were governance processes and oversight in the surgical division. Staff at all levels were clear about their responsibilities, roles and accountability within the governance framework. However, there were areas for improvement which had been identified which were not addressed in a timely manner, for example late start to theatres and delays in discharge from recovery. This impacted on the responsiveness of the service, and we were not assured of the oversight and action with regards to this. Although the theatre transformation project was now picking these concerns up.

Each specialty governance group was responsible for their own reviews of mortality and morbidity within their clinical governance structures. Governance arrangements had good attendance from medical staff. Consultants told us how a regular monthly mandatory meeting was held and had a fixed agenda covering: mortality and morbidity, incident reports, and NICE guidance compliance.

We heard about regular ward and theatre meetings being held, which enabled important information to be shared with staff.

An extensive set of policies, was readily available on the intranet and was supported by standard operating procedures and processes. This ensured staff could work according to best practice guidance.

Management of risk, issues and performance

The trust had effective systems for identifying risks. Risk was managed at a local level, for example in wards, units and theatres, and escalated to the surgical directorate risk register, and then corporate risk register, dependent on severity of risk.

The risk register did not have the action summary and actions completed. We were therefore unable to see the date the risk was reviewed and any progress or updates with the risks. We reviewed risk registers sent as part of the data request for theatres, Steephelm, surgical directorate and corporate. It was difficult to understand the current status of each risks and risks had expired their review date. However, we recognise the trust had recently moved to a new system for recording their risks, therefore there was a possibility this information had not been updated.
The risks in the service were understood by staff and leaders. The wards understood, recognised and reported their risks. There was a risk register and we noted this had been kept up to date. Risks were shown on the risk register with actions required and taken and a review date. Reference was made to known risks, including staffing, the availability of rehabilitation beds, falls prevention, pressure ulcers, increased length of stay and training compliance. The theatre team which included the theatre matron and two theatre sisters met monthly to review their risks. When speaking they were able to talk confidently about the risks on the risk register and how these were being managed.

There was a trust major incident plan which outlined the decisions and actions to be taken to respond to and recover from a range of consequences caused by a significant disruptive event. The staff we spoke to were aware of the trust major incident plan and how to access this.

The hospital had an emergency preparedness policy. This covered any occurrence which may present a serious threat to the health of the community. This included disruption to the service or caused such numbers or types of casualties as to require special arrangements to be implemented by the hospital. Staff knew how to access the plan in an emergency.

Information management

There were compatibility issues with IT systems across the trust. Staff said it was difficult to coordinate between multiple systems and this could hamper delivery of effective care and treatment.

A number of IT systems were used by the access team, because systems did not interface with each other. This added unnecessary time when managing bookings and potential for error. However, the team were confident in their processes.

An electronic board system was introduced, this was an interactive functionality to help inform treatment plans and discharge planning. It showed the flow and status of patients on the wards. Information captured nursing alerts, nursing assessment tool, infection prevention and control, pressure ulcers, mobility, safeguarding, NEWS, diet, observations, urine, the social plan, discharge status and transport requirements. It was also possible to identify an alert for DoLS, however, staff said it was not possible to identify the status of the DoLS application, and this was being looked at by IT colleagues.

Engagement

There were systems to engage with the public to ensure regular feedback on services. This was used for and learning and development. Patients were encouraged to complete a friends and family test (FFT) form. Patients could also comment through social media. Themes had emerged from the patient survey. There continued to be a perception amongst patients that wards and departments did not have enough staff. There were also comments about the poor standard of food.

Regular meetings and emails gave opportunities for feedback about governance issues such as incidents, complaints and risk assessments. Performance and continuous improvement was also assessed through discussions about essential training, clinical skills and competencies. Staff said they could express their opinions and raise concerns through directorate and trust-wide forums. Information was provided to staff through newsletters and displayed on notice boards in ward office areas.

Achievement was recognised to held engage and reward staff. A Wonderful Weston Super Stars social media page was available where staff could thank one another. There were monthly pride values awards and an annual celebration of success award ceremony.
Engagement opportunities with the executive team were available. ‘Ask James’ meetings were available for staff to meet the chief executive informally. There were monthly executive walk rounds to engage with staff.

**Learning, continuous improvement and innovation**

The surgical service concentrated on sustainability and best practice to continually learn and improve, there was therefore limited innovation. The staff teams told us they were always keen to learn and develop the service. Innovation and improvement was encouraged with a positive approach to achieving best practice.

Opportunities for research were limited and there was no examples of outstanding practice or innovation. It was difficult to see how this will improve while the trust remains in a state of uncertainty.

Staff and managers felt there was scope and a willingness amongst the team to look for potential innovative solutions, to continue to ensure the delivery of high quality care for patients and develop services.

There were new trust-wide roles including the chief registrar role and the lead nurse for the deteriorating patient and sepsis. The lead nurse role has been instrumental in identifying and rapidly treating patients with early signs of sepsis and embedding practice across the trust. The chief registrar working with the quality improvement hub had supported better clinical engagement from junior doctors and the wider clinical workforce. The chief registrar had developed a trust wide quality and safety publication (WeSMILE) to improve learning from mortality reviews and incidents as well as leading key quality improvements (VTE and discharge summaries).

The stoma nurse for enhanced recovery spoke internationally at a conference in recognition of the successful work completed.

Hutton ward received a national award for their work in relation to hip fracture quality improvement project.

The trust introduced a web based app to collect quality of care audit information and feedback from patients, for inpatient wards. Four audits were completed each week by a ward manager, head of nursing or matron. This enabled the trust to use data to review quality and report this from ward to board, and real time data used to ensure wards are safe.

A transformation team had been introduced in the last year to assist and support in the delivery of key quality projects. Theatres were identified as a key priority, work was being completed to review the effectiveness and responsiveness of theatres to be able to learn and improve the service being provided.

### Mental health services

**Specialist community mental health services for children and young people**

**Facts and data about this service**

<table>
<thead>
<tr>
<th>Location site name</th>
<th>Team name</th>
<th>Number of clinics</th>
<th>Patient group (male, female, mixed)</th>
</tr>
</thead>
</table>

166
RA3 Weston Area
Health – RA305 drove Road, RA319 The Barn Clevedon

Child and adolescent mental health services and child transition services (CAMHS)

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

**Safe and clean environment**

The environments were clean and well maintained. Interview rooms had been fitted with alarms so that staff could call for assistance, staff responded to the alarms.

Management had not assessed the ligature risk of the environments at the two sites we visited. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. We requested to see health and safety assessments of the environment. Management could not produce a ligature assessment but had completed an abscondion assessment and a separate anti-barricade assessment following an incident with a young person which included tying a ligature, staff were aware of this assessment. Therefore, they had not made the team aware of the potential ligature risks of the environment on young people. Staff worked with young people with a ligature, deliberate self-harm and suicide risk so the risk of suicide on the premises was included in the services risk register. The general manager of the service stated that they would expect to see a ligature assessment, environmental assessment and a health and safety assessment of the buildings.

Clinic rooms were clean and well stocked to help staff monitor young people’s physical health. Physical monitoring equipment was clean and calibrated to ensure accuracy, for example, when taking blood pressure or weight.

Handwashing signs were visibly posted around the site above basins and in rooms. This ensured that staff were reminded to stay clean to help prevent the spread of infection.

**Safe staffing**

The capacity of the team did not meet the demand on the service. The provider had determined the amount of staff required but had identified the need to expand the team further due to a long waiting list and to increase the ability of the service to respond to a crisis. Staff had noticed a high number of staff leaving and at the time of the inspection there were vacancies for a psychiatrist, two psychologists, one art therapist and a mental health practitioner. There were also three further posts to be filled for the urgent and crisis referrals.

We spoke to staff who felt under pressure due to staff shortages, there had been an increased pressure on the service due to an increase in referrals and this had made waiting lists increase due to fewer staff to take a caseload. Staff were required to take young people on their caseload if a staff member left the service. Management tried to mitigate the risk of vacancies through the use of locum, bank or agency staff. During the inspection there was one member of agency staff brought in to fill one of the vacant posts for the urgent and crisis response.

Staff held higher caseloads than officially recorded as staff did not feel comfortable discharging some cases due to risk. The team caseload on the first day of the inspection was 663. Clinical leads were supposed to review individual caseloads to help staff manage the size but not all staff received this. We found that some staff had an active caseload which was reflected in their
caseload numbers, but also held an extra caseload of young people that they did not want to
discharge due to risk but had come to the end of their treatment. As a result, staff held them on a
review caseload to see them regularly to provide support. Staff had felt that cuts to tier 2 services
had impacted the caseload.

There were cover arrangements in place for sickness, vacancies and annual leave. Staff worked
together to share the risk of young people to ensure that if needed, someone was able to see
them while they were off. For example, a clinician was allocated to a duty service called clinician
advisor of the day (CAD) who could take calls or respond to young people calling in.

Nursing staff

This core service has reported a vacancy rate for all staff of 20% as of 30 November 2018.

This core service reported an overall vacancy rate of 66% for registered nurses at 30 November
2018.

This core service reported an overall vacancy rate of 11% for nursing assistants.

<table>
<thead>
<tr>
<th>Location</th>
<th>Ward/Team</th>
<th>Registered nurses</th>
<th>Health care assistants</th>
<th>Overall staff figures</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Vacancies</td>
<td>Establishment</td>
<td>Vacancy rate (%)</td>
</tr>
<tr>
<td>RA3 Drove Road, RA3 The Barn Clevedon</td>
<td>Child and adolescent mental health services and chid transition services (CAMHS)</td>
<td>9.8</td>
<td>16.2</td>
<td>60%</td>
</tr>
<tr>
<td>RA3 Drove Road, RA3 The Barn Clevedon</td>
<td>Community Paediatrics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Core service total</td>
<td></td>
<td>9.8</td>
<td>16.2</td>
<td>60%</td>
</tr>
<tr>
<td>Trust total</td>
<td></td>
<td>1,250</td>
<td>4,918</td>
<td>25%</td>
</tr>
</tbody>
</table>

NB: All figures displayed are whole-time equivalents

This core service had 3 (16%) staff leavers between 1 December 2017 and 30 November 2018.
<table>
<thead>
<tr>
<th>Location</th>
<th>Ward/Team</th>
<th>Substantive staff (at latest month)</th>
<th>Substantive staff Leavers over the last 12 months</th>
<th>Average % staff leavers over the last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>RA3 Drove Road, RA3 The Barn Clevedon</td>
<td>Child and adolescent mental health services and child transition services (CAMHS)</td>
<td>18.6</td>
<td>3</td>
<td>16.1</td>
</tr>
<tr>
<td>RA3 Drove Road, RA3 The Barn Clevedon</td>
<td>Community Paediatrics</td>
<td>2.5</td>
<td>3.6</td>
<td>144%</td>
</tr>
<tr>
<td><strong>Core service total</strong></td>
<td></td>
<td>21.1</td>
<td>6.6</td>
<td>31%</td>
</tr>
<tr>
<td><strong>Trust Total</strong></td>
<td></td>
<td>731.5</td>
<td>136</td>
<td>18%</td>
</tr>
</tbody>
</table>

The sickness rate for this core service was 6.1% between 1 August 2017 and 30 November 2018. The most recent month’s data (30 November 2018) showed a sickness rate of 5.6%.

<table>
<thead>
<tr>
<th>Location</th>
<th>Ward/Team</th>
<th>Total % staff sickness (at latest month)</th>
<th>Ave % permanent staff sickness (over the past year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>RA3 Drove Road, RA3 The Barn Clevedon</td>
<td>Child and adolescent mental health services and child transition services (CAMHS)</td>
<td>1.0%</td>
<td>2.7%</td>
</tr>
<tr>
<td>RA3 Drove Road, RA3 The Barn Clevedon</td>
<td>Community Paediatrics</td>
<td>40.0%</td>
<td>21.9%</td>
</tr>
<tr>
<td><strong>Core service total</strong></td>
<td></td>
<td>5.6%</td>
<td>6.1%</td>
</tr>
<tr>
<td><strong>Trust Total</strong></td>
<td></td>
<td>5.0%</td>
<td>17.9%</td>
</tr>
</tbody>
</table>

**Medical staff**

From December 2017 to November 2018, of the 13,538 total working hours available, 15% were filled by bank staff and 58% were covered by locums to cover sickness, absence or vacancy for qualified nurses.

The main reasons for bank and locum usage for the wards/teams were due to vacancies.

In the same period, none of available hours were unable to be filled by either bank or locum staff.

<table>
<thead>
<tr>
<th>Ward/Team</th>
<th>Total hours available</th>
<th>Bank Usage</th>
<th>Agency Usage</th>
<th>NOT filled by bank or agency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
</tr>
<tr>
<td>Child and adolescent mental</td>
<td>5217</td>
<td>226</td>
<td>4%</td>
<td>168</td>
</tr>
</tbody>
</table>
Psychiatrists stated that there was not enough psychiatry access within the service. At the time of the inspection there were 2.4 whole time equivalent (WTE) psychiatrists in post with a locum covering one WTE caseload but over three days. Staff were able to refer internally to psychiatrists but there was a wait for this service due to the large size of the caseloads for psychiatry.

**Mandatory training**

Staff were not up to date with mandatory training with overall compliance at 75% on the first day of the inspection.

The compliance for mandatory and statutory training courses at 30 November 2018 was 77%. Of the training courses listed 11 failed to achieve the trust target and of those, four failed to score above 75%.

The trust set a target of 90% for completion of mandatory and statutory training.

Training figures are calculated on a rolling 12-month basis.

The training compliance reported for this core service during this inspection was higher than the 74% reported in the previous year.

**Key:**

<table>
<thead>
<tr>
<th>Below CQC 75%</th>
<th>Met trust target</th>
<th>Not met trust target</th>
<th>Higher</th>
<th>No change</th>
<th>Lower</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Number of eligible staff</th>
<th>Number of staff trained</th>
<th>YTD Compliance (%)</th>
<th>Trust Target Met</th>
<th>Compliance change when compared to previous year</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREVENT</td>
<td>27</td>
<td>29</td>
<td>93%</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>27</td>
<td>29</td>
<td>93%</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Counter Fraud Awareness</td>
<td>23</td>
<td>29</td>
<td>79%</td>
<td>✗</td>
<td>✓</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>23</td>
<td>29</td>
<td>79%</td>
<td>✗</td>
<td>✓</td>
</tr>
<tr>
<td>Training Module</td>
<td>Number of eligible staff</td>
<td>Number of staff trained</td>
<td>YTD Compliance (%)</td>
<td>Trust Target Met</td>
<td>Compliance change when compared to previous year</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>--------------------------</td>
<td>-------------------------</td>
<td>--------------------</td>
<td>------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>23</td>
<td>29</td>
<td>79%</td>
<td>x</td>
<td>✅</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>23</td>
<td>29</td>
<td>79%</td>
<td>x</td>
<td>✅</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>23</td>
<td>29</td>
<td>79%</td>
<td>x</td>
<td>✅</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>22</td>
<td>29</td>
<td>76%</td>
<td>x</td>
<td>✅</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3 Additional)</td>
<td>22</td>
<td>29</td>
<td>76%</td>
<td>x</td>
<td>✅</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>21</td>
<td>29</td>
<td>72%</td>
<td>x</td>
<td>🔻</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>20</td>
<td>29</td>
<td>69%</td>
<td>x</td>
<td>🔻</td>
</tr>
<tr>
<td>Information Governance</td>
<td>20</td>
<td>29</td>
<td>69%</td>
<td>x</td>
<td>🟢</td>
</tr>
<tr>
<td>Fire safety</td>
<td>16</td>
<td>29</td>
<td>55%</td>
<td>x</td>
<td>➔</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>377</td>
<td>290</td>
<td>77%</td>
<td></td>
<td>🟢</td>
</tr>
</tbody>
</table>

### Assessing and managing risk to patients and staff

#### Assessment of patient risk

Staff did not document risk assessments of all young people receiving care within the service. At the previous inspection in 2015 we found there to be comprehensive risk assessments. We reviewed 15 sets of care records throughout the inspection including young people at risk of self-harm and suicide, young people with an eating disorder and young people receiving medication. There was no clear risk assessment tool being used universally by the staff and it was unclear where risk information was kept within the paper files. A risk form that rated risks had been used for two young people but these were incomplete and had not rated the presenting risks. There was a lack of documented risk formulation which is used by mental health professionals to estimate and manage risks for mental health young people. For example, a young person with a previous incident of a substantial overdose who had been referred to safeguarding had not had a formal risk assessment to identify and mitigate the risk of a future overdose. Therefore, it was not clear if staff understood and knew the risks of young people to help manage them.

Staff used safety plans with young people to help them in the event of crisis, for example in the event of absconding, or barricading themselves. However, there was limited personalised information within these plans as they appeared to be predominantly tick boxes. There was no evidence as to whether these had been given to the young people that they were meant for.

#### Management of patient risk

There was no weekend cover by the team, so crises were diverted to A&E. Staff responded to crises and provided assessment after being informed by the child and adolescent treatment,
assessment and outreach team at the local children’s hospital. This meant that staff had to be diverted from their scheduled duties to respond.

Staff did not protect young people from avoidable harm because they did not actively monitor the waiting list or revisit the risks of young people waiting to access treatment. Management told us that there had been 86 referrals received in January 2019 with 39 accepted to go on the waiting list which held 272 young people waiting for treatment, the longest wait was 44 weeks. However, we were then told that this data was potentially not accurate and that they were unsure what the real numbers were and could not find this out. At the previous inspection in 2015 there was regular contact made with young people waiting for treatment. We reviewed two months of the waiting list. Staff did not pro-actively follow up referrals on the waiting list to look at the risks and to assess whether risks had increased by contacting young people and families. Further to this there had been a young person with a serious overdose requiring hospitalisation, who was a suicide risk and risk to others and another experiencing psychosis that had not had any follow up. These had waited many months and there had been no further contact from the service despite one having had a GP follow up on two further occasions.

Once staff received the referral and triaged to accept for treatment, admin staff sent a letter notifying them that they had been accepted for treatment. The letter provided links to online support and services to access during this time but there was a spelling mistake which meant that the website for the Samaritans was wrong.

Staff had personal safety protocols which included a safe word if they were at risk in the community. This meant that staff could support each other to stay safe when working remotely.

**Safeguarding**

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

Information provided prior to the inspection showed this core service made no safeguarding referrals between 1 August 2017 and 30 November 2018. However, through speaking to staff and reviewing clinical records it became clear that there had been safeguarding referrals made. Staff knowledge of safeguarding procedures and their links with the safeguarding nurse was robust. There was well documented evidence of working with the local authority to safeguard young people from abuse.

The trust had submitted details of three serious case reviews commenced or published in the last 12 months (1 August 2017 and 30 November 2018). Two related to this service.

**Staff access to essential information**

There was an unsafe culture in the use of paper records that had compromised the care of young people while impacting on their confidentiality. Staff did not maintain young people’s confidentiality through safe record keeping due to missing files. We reviewed incidents for the service and spoke to staff and found that paper records had gone missing and that notes were often not legible. For example, following a call from the local hospital regarding a young person in
crisis, staff had raised an incident due to the paper file impeding their ability to respond to the crisis. Staff had raised many incidents of files missing including files for psychiatric and therapy appointments. One file had been missing for many months due to it being taken home by a locum psychiatrist and never returned. This had meant that there was no access to cognitive behavioural therapy worksheets, initial goals or progress notes and had therefore had a detrimental impact on therapy. Poor record tracking impacted on staff’s ability to know who had the records and to ensure that the records were stored securely protecting young people’s confidentiality. Staff expressed their concern at the use of paper records and were universally critical of the situation where they still had to use paper records. A plan had been put in place to change to an electronic records system but this had not been finalised at the time of the inspection.

Medicines management
Medicines were not stored at either location inspected.
Staff monitored the physical health of young people receiving medicines to ensure that any changes were responded to.

Track record on safety
Between 1 August 2017 and November 2018 there were no serious incidents reported by this service.
A ‘never event’ is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This service reported zero never events during this reporting period.

Reporting incidents and learning from when things go wrong
Staff used an electronic records system to record and escalate incidents, however, there was concern that not all incidents involving young people had been recorded. Staff said that they only recorded incidents that occurred on site and would not record high risk incidents involving young people in the community. This meant that the increasing complexity and risk of the caseload was not recorded to escalate to senior management. For example, when we reviewed clinical records there were clear incidents identified involving suicide attempts and serious self-harm that had resulted in hospitalisation that had not been recorded. Another incident involving physical harm to a young person resulting in hospitalisation had not been recorded as an incident either. However, there were a high number of incidents recorded around the use of paper records.

Learning from incidents was not robust enough to prevent repeated incidents occurring. Management had not acted upon the high number of recorded incidents involving the paper records to prevent the issue reoccurring. We reviewed minutes of business and governance meetings and found that there was no action taken to change practice around this issue. Staff we spoke with had not had any specific learning from incidents cascaded to change practice.

The Chief Coroner’s Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.
In the last two years, there have been no prevention of future death reports sent to Weston Area Health NHS Trust.

Is the service effective?
Assessment of needs and planning of care

Staff completed a mental health assessment of young people entering the service. Staff used the choice and partnership approach (CAPA) which is a model of engagement and clinical assessment principally used in child and adolescent psychiatry services. It aims to use collaborative ways of working with service users to enhance the effectiveness of services and user satisfaction with services. The assessments included, where needed, a physical health assessment. Staff felt that the young people coming into the service were of increasing complexity and that the CAPA model did not necessarily work for them because they needed longer spells of treatment.

Staff did not document care plans for all young people but set goals, however, this was not evident in all notes we reviewed. Of the 15 notes we reviewed there was only one set of notes that had clear goal setting that had included the young person. It was therefore not clear what the plan was for young people accessing the service.

Where a young person had been in hospital there was well documented care programme approach (CPA) notes with joined up working with other professionals and services such as social services.

Best practice in treatment and care

Care pathways that guided staff on the treatment to provide according to a young person’s presentation, were created according to National Institute for Health and Care Excellence (NICE) guidance. All clinical/therapy staff followed NICE guidance and other nationally or internationally recognised evidence based guidelines or best practice. Staff were extremely knowledgeable about the evidence base for the different types of therapies that that they delivered, including being up to date with the latest research.

Medical staff prescribed and monitored medication in line with NICE guidance.

Young people accessing the eating disorder pathway received a comprehensive physical health assessment and then revisited to monitor treatment progression. This included regular height and weight and blood tests. At the time of the inspection there was no dietician for the eating disorder pathway, there was a plan in place to approach the local children’s hospital to get dietetic support.

Staff encouraged healthy living in young people. For example, eating well and the importance of sleep. This was extended to the families as well as the young people so that they could work on healthy lives together. For example, taking technology out of bedrooms to encourage healthy sleeping habits.

Staff used recognised rating scales to show progression through treatment. For example, the revised children’s anxiety and depression scale (RCADS) and the strengths and difficulties questionnaire (SDQ). However, the service was in the planning stages of collating outcomes data to show the effectiveness of the treatment they provided. At the time of the inspection, staff were working on securing a database to capture this data to show the overall trends of the service.

This service participated in two clinical audits as part of their clinical audit programme 2018.
<table>
<thead>
<tr>
<th>Audit name</th>
<th>Audit scope</th>
<th>Core service</th>
<th>Audit type</th>
<th>Date completed</th>
<th>Key actions following the audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit of assessment of mild, moderate, severe depression against diagnostic criteria in ICD-10</td>
<td>CAMHS</td>
<td>Specialist community mental health services for children and young people</td>
<td>Clinical</td>
<td>01/03/18</td>
<td>None</td>
</tr>
<tr>
<td>A pilot of a risk assessment measure within a CAMHS Learning Disabilities Team</td>
<td>CAMHS</td>
<td>Specialist community mental health services for children and young people</td>
<td>Clinical</td>
<td>01/06/18</td>
<td>This audit report will be sent to the CAMHS-LD management team to support the development of risk assessment and management practices in the service.</td>
</tr>
</tbody>
</table>

**Skilled staff to deliver care**

The team comprised of a range of professionals including psychiatrists, nurses, occupational therapists, art therapists, family therapists, social workers and psychologists. Staff were experienced and qualified to undertake the role that they were recruited for.

Staff expressed concern that there were not the staff with the correct skills to support all the pathways provided. The pressure and lack of capacity within the service meant that staff were allocated young people because they had space on their caseload rather than because they were the correct staff member to provide the treatment.

New staff did not receive appropriate induction to the service. We saw an induction document used for new starters, but it was felt there was a lack of support to train new staff to the standard and level to ensure young people were kept safe and that they felt part of their new team. We requested the induction pack for new staff which consisted of the paperwork used at the service.

Staff did not all receive regular clinical supervision to provide them with opportunity for reflective practice. Staff told us that they were not regularly receiving managerial supervision as a result of increased caseloads and responsibilities. We found an example of a member of staff recruited that had inadequate support and mentoring to do the role and as a result had left. Staff expressed concern about the lack of support being provided to them due to the pressures on the service and the limited time available for support from their line managers. We requested supervision data, but this was out of date by a number of years so there was no data of the support provided.

There was limited specialist training open to staff working at the service. Staff felt that there was limited scope to progress. Staff had not been provided the opportunity to be promoted into higher bands without leaving and working as bank workers.
The trust’s target rate for appraisal compliance is 85%. At the end of last year (April 2017 and March 2018), the overall appraisal rate for non-medical staff within this service was 74%. This year so far, the overall appraisal rates was 65% (as at November 2018).

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total number of permanent non-medical staff requiring an appraisal</th>
<th>Total number of permanent non-medical staff who have had an appraisal</th>
<th>% appraisals (as at November 2018)</th>
<th>% appraisals (previous year April 2017-March 2018)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child and adolescent mental health services and child transition services (CAMHS)</td>
<td>17</td>
<td>11</td>
<td>65%</td>
<td>73%</td>
</tr>
<tr>
<td>Community Paediatrics</td>
<td>1</td>
<td>0</td>
<td>0%</td>
<td>75%</td>
</tr>
<tr>
<td>Core service total</td>
<td>18</td>
<td>11</td>
<td>65%</td>
<td>74%</td>
</tr>
<tr>
<td>Trust wide</td>
<td>775</td>
<td>625</td>
<td>80%</td>
<td>76%</td>
</tr>
</tbody>
</table>

During the inspection we requested data to show the adherence to supervision, but this was not produced and did not exist.

There was no data for medical staff for this core service.

There was no data provided for clinical supervision for this core service.

There was no data provided for clinical supervision for this core service.

**Multi-disciplinary and interagency team work**

Staff held multi-disciplinary meetings to discuss treatment progress in young people. This included using CPA meetings to move forward with care and triage meetings to discuss referrals received by the service. We observed multi-disciplinary meetings of staff working with young people with eating disorders and young people with an autistic spectrum disorder. We found excellent multidisciplinary and interagency working practices with effective communication between team members and other professionals. There was evidence of interagency working with social services around safeguarding concerns and for planning care with looked after children.

Staff described good working links with local agencies although acknowledged that the provision of external services had reduced due to austerity cuts.

**Adherence to the Mental Health Act and the Mental Health Act Code of Practice**

As of 30 November 2018, there is no data pertaining to Mental Health Act training for all staff within this core service.

**Good practice in applying the Mental Capacity Act**

The Mental Capacity Act applies to young people aged 16 or over. For children under the age of 16, the young person’s decision-making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves. The staff we spoke to were conversant with the principles of Gillick and...
used this to include the young person where possible in the decision making regarding their care. However, we did not see any documentation of these decisions.

As of 30 November 2018, there is no data pertaining to Mental Capacity Act training for all staff within this core service.

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### Is the service caring?

**Kindness, privacy, dignity, respect, compassion and support**

Staff demonstrated a clear attitude of respectful, compassionate care. We saw them interact with young people in a way that showed they were dedicated to protecting young peoples’ dignity as well as keeping them safe. The young people we spoke with praised the staff highly, saying that they were caring and wanted what was best for them.

Young people could have open discussions about their personal, cultural, social and religious needs with staff, as they knew staff would respect their wishes and help meet their needs. We saw that staff had taken steps to help a young person to stay engaged within the community and remain in contact with a local learning disability service. Staff were keen to promote a culture of respect and assured young people that they were safe to raise any allegations of discriminatory behaviour.

**Involvement in care**

**Involvement of patients**

Young people expressed that they had a choice in the care that they received.

There was a comment tree at the two sites for young people to feedback on the service.

Staff were skilled at using a range of communication tools to help patients communicate their wishes. Staff used these tools to help patients be involved in their care, and to give them information about their care in a way they could understand.

**Involvement of families and carers**

Carers felt their relatives were receiving high quality care from a staff team that was dedicated to helping them. The service provided a parents and carers group to help families of the young people receiving treatment. This was around what to expect and helping with understanding the first assessment. Staff offered day and evening slots to offer as much opportunity as possible for people to attend.

Carers we spoke with said staff were very supportive. They felt they were involved in their relatives’ care, and that staff could support them as well when they needed it.

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### Is the service responsive?

**Access and waiting times**

There were extensive waits for the service that put young people at risk and breached the 18-week referral to treatment target set by commissioners. The service received referrals through a single point of referral and these were screened and triaged by a minimum of two staff twice weekly. There were criteria to offer young people a service and a waiting list in operation, however, there was an extensive wait for a service of up to 44 weeks for routine referrals. The average overall wait was 12 weeks, however this included urgent referrals which were seen much quicker. Staff previously assessed young people in a choice appointment at the earliest opportunity once referred and then placed them on a waiting list for the partnership appointments which was where treatment
started. The service had changed this approach to having the waiting list external to the service so staff placed young people on a waiting list for the initial assessment appointment. This had meant that there were consistently high waits for young people needing a service and receiving a first comprehensive assessment. There were 121 young people waiting over 18 weeks at the time of the inspection in February 2019 but the number had peaked in May 2018 when the service received a larger number of referrals. Staff felt that the impact of losing tier two services had affected the health of young people due to reduced community support that they would traditionally access prior to being referred to CAMHS.

The long waits had impacted on the health of young people and restricted who was offered a service, the service was running at full capacity and therefore could only accept the riskiest cases. We reviewed records and incidents and found that parents had seen a progressive decline in a young person’s mental state due to having to wait for so long. A young person referred who had a suicide risk was not accepted due to age because staff had anticipated that the person would be over 18 by the time a service was offered.

The pressure on the service had impacted the number of referrals being rejected and therefore young people were being re-referred into the service. A list of re-referrals had been started in December 2017 but there was uncertainty as to whether or not all re-referrals into the service had been included on it. At the time of the inspection there were around 444 re-referrals since December 2017.

There was limited capacity within the team to provide more intensive support to those experiencing crisis. The service did not have a dedicated crisis team but provided urgent assessment through the rapid access clinic (RAC) to young people within 14 days of referral. All staff covered the RAC and took young people onto their caseloads if needed. The clinician of the day received urgent referrals for the RAC and then reviewed these to see if they were appropriate for the clinic. Following this triage, if accepted, the young person was offered the next available appointment.

After assessment the service waited until there was a partnership appointment to start treatment and this was dependent on staff caseloads as to whether they could provide support. Young people were waiting between two to three months between initial assessment and treatment. The provider had secured money to provide a crisis team in the service, however, it became clear that the money was not sufficient enough to provide a complete crisis service so there were plans in place to support the RAC provision with more staff and to increase the capacity of the service.

The service had a clinician of the day service to respond to young people and families phoning into the service. Staff had been allocated a day per week to be clinician of the day on top of their caseload. Staff felt that this impacted on their ability to provide time to young people on their caseload and therefore slowed down the flow through the service.

The service followed up young people who did not attend appointments and had a process in place to engage young people that were harder to engage. This included working with other organisations and schools, for example to maximise opportunity for engagement. Appointments were only cancelled when absolutely necessary. However, there was no oversight of this so the service could not produce proof that every young person was being seen.

The service had developed a transition procedure with adult mental health services for young people that required the service after the age of 18. However, this was not being implemented correctly and there had been difficulties with the timeliness of transitioning young people.
The facilities promote comfort, dignity and privacy

There were a range of rooms at both sites for staff to see young people, however, staff complained that often there were not enough rooms available and we found this in a recorded incident. The waiting area had toys and books for young people to play with while waiting for their appointment. Staff cleaned these regularly. Soundproofing had been enhanced by use of white noise machines in waiting areas.

Patients' engagement with the wider community

Staff worked with young people to access work and education outside of the service if they desired. Emphasis of treatment was not just on symptoms and illness but included the wider view of a young person’s life and their hobbies and preferences. However, due to austerity cuts there were fewer services around the area to engage young people with.

Meeting the needs of all people who use the service

Both sites had good disabled access and staff responded to specific needs of young people such as language barriers through access to interpreters.

There was a wide variety of information through leaflets and posters in the waiting areas of the two sites including information about feedback/complaints, Citizens Advice Bureau, homophobia, national careers service, anxiety and depression for example.

This service received 33 complaints between December 2017 to November 2018. Twenty-one of these were upheld, six were partially upheld and two were not upheld. None were referred to the Ombudsman.

We reviewed a number of complaints and found that people received a response from the service. However, there were two occasions where the complaint response had not included the views of the clinician involved and therefore did not give a full picture of what had occurred. There was evidence of discontent from staff for this reason. Two of the complaints had taken a very long time of over two months to respond to.

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Complaints</th>
<th>Fully upheld</th>
<th>Partially upheld</th>
<th>Not upheld</th>
<th>Under Investigation</th>
<th>Withdrawn</th>
<th>Referred to Ombudsman</th>
</tr>
</thead>
<tbody>
<tr>
<td>DROVE ROAD (CHILDRENS SERVICES)</td>
<td>31</td>
<td>20</td>
<td>6</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>THE BARN (CHILDREN SERVICES)</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

This service received 15 compliments during the last 12 months from 1 August 2017 to 31 July 2018 which accounted for 3% of all compliments received by the trust as a whole.

Is the service well led?
Leadership

The pressure on the service working to full capacity had restricted the clinical leads ability to dedicate time to the management role. The service was not well led and there was a lack of ownership in management. The leadership structure had been established as a structure with three clinical leads and a business manager below a general manager who oversaw several different services. This had created a situation where management time was split with clinical time for the leads. Two of the clinical leads had resigned prior to the inspection. Staff and clinical leads expressed the need to have a clinical services manager as the current way of working was not sustainable, lacked any accountability and ownership of management responsibilities.

Staff expressed concerns with safety, vacancies and capacity of the service and we were shown evidence of these concerns being raised that had not been acted on promptly and effectively. This had meant that staff felt that they were not practicing safely. Staff expressed that they did not feel that concerns were taken seriously and that communication from above them was not joined up, meaning that they did not have a consistent message. Staff said that the poor communication was creating a ‘toxic environment’. Staff felt that line managers were too busy and that issues raised in sessions such as supervision were not acted upon.

Vision and strategy

Staff felt that the trust did not understand the service and that concerns with the service had not been taken seriously by them. At the time of the inspection a meeting had been called for staff to express their concerns about the situation and this was fed back to the trust at the end of the meeting. The meeting gave staff the opportunity to talk about the safety of the service. Staff did not feel that they were supported by the trust, they felt forgotten due to being the only mental health service in an acute trust and that they were not a priority. Staff did not feel they were in the position to deliver high quality care in the current situation.

Culture

The lack of effective management had impacted the culture of the service. Staff consistently reported that they did not feel respected, supported or valued at work, there was a lack of pride working for the service although they were all dedicated to helping young people. At the commencement of employment, new staff felt a burden to the team.

Morale had reached ‘rock bottom’ and there was the sense that there was no point in raising concerns about the work they did due to the lack of response from the past. Staff did not feel that using the whistleblowing process would bring change.

Staff reported high levels of stress and not being happy at work and that success was not celebrated. They did not feel listened to about promotion or development in their role and that the appraisal process did not provide them opportunity for the future. Staff did not feel valued due to a lack of promotion opportunity for substantive staff without leaving. There had been a high turnover of staff which had created a situation where staff were waiting to see who would leave next.

Governance

The governance arrangements did not improve the quality of the service and the governance meeting functioned inadequately. Waiting list size had not been addressed affectively and the lack of ownership around incident reviews had meant that incidents had re-occurred. The distinct lack of direction around management of risk on the waiting list had needlessly placed young people at risk of deteriorating mental health and avoidable harm and this was evidenced in incidents and records. The governance meeting had occurred only twice since June 2018 and the meeting
minutes for the September meeting contained limited information. Staff felt business meetings were not regular enough to be useful and did not provide time for them to discuss issues.

There were inadequate systems in place to have oversight of the safe running of the service, this meant that senior management were not sighted on areas such record completion, outcome measures, supervision or safety of the environments for example. The general manager indicated that he had no data which would indicate an effectively functioning and well led service and there was a lack of auditing against their pathways to prove effectiveness.

The data systems in place at the time of the inspection meant that there was unreliable information bring provided and there was no oversight that guaranteed staff were seeing young people. Information provided to us such as waiting list numbers, re-referrals and average wait we were told were not guaranteed to be accurate. There was a lack of ownership around this information that meant it was difficult to build an accurate picture, staff did not know where data was kept or if it existed.

Management of risk, issues and performance

The service kept a risk register to escalate the main risks and to come up with an action plan, but this was ineffective and did not reflect the true risk of the service. Staff shortages, lack of resources for specialist interventions and risk of harm on site were included but there had been clear inaction around some of these risks. For example, around the lack of monitoring of building risks.

The service received a critical friend report from a professional external to the service to help them identify performance issues and a potential way forward. The report highlighted issues with the long waiting lists and the impact of using an ineffective model of care in using CAPA due to the lack of resources to implement it. Staff said to the inspection team that they did not feel that CAPA worked for them. The report also highlighted the lack of a manager, data systems to capture performance data and the lack of recording supervision data as issues. The report said that the service would likely function more effectively as a demand and capacity model.

Information management

Staff did not have the required technology to collate data around performance of the service or record keep effectively and safely. Paper notes were not managed safely and posed a risk to young people’s confidentiality and data protection. The high number of paper record incidents had not been acted upon to ensure the safety and effective treatment of young people.

Engagement

Young people and carers were given the opportunity to feedback to the service using the friends and family test, but this was not being widely used by staff.

Staff did not feel engaged with the service but had been given the opportunity to talk about the issues with the service on the week of the inspection. Following this meeting staff had agreed to meet to come up with an action plan to address some of the issues they faced.

Young people did not have the opportunity to engage with the service due to the cutting of the participation worker. The participation worker previously maximised engagement which helped young people feedback on changes to the services, help shape the service and recruit staff for example.
Learning, continuous improvement and innovation

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The trust provided a list of accreditations which have been undertaken, however there is no data pertinent to this core service.