Weston Area Health NHS Trust

Quality Report

Weston General Hospital,Grange Road
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Date of inspection visit: 28 February 1,2,9,10,13 and 14 March 2017
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This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out a focused follow up inspection at Weston Area Health Trust between 28 February and 2 March 2017 and returned to visit some wards and departments unannounced on 9, 10, 13 and 14 March 2017.

This inspection was to follow up on the findings of our previous inspections in May and August 2015, when we rated the trust as requires improvement overall. Medical care was rated as inadequate, urgent and emergency care, critical care and surgery were rated as requiring improvement and maternity and gynaecology, services for children and young people, outpatients and diagnostic imaging and end of life care were all rated as good.

At this inspection we inspected the following services at Weston General Hospital

- Urgent and emergency care
- Medical care including care of the elderly
- Surgery
- Critical care

We did not inspect

- Maternity and gynaecology
- Children and young people
- Outpatients and diagnostic imaging
- End of life care

As part of this inspection, CQC piloted an enhanced methodology relating to the assessment of mental health care delivered in acute hospitals; the evidence gathered using the additional questions, tested as part of this pilot, has not contributed to our aggregation of judgements for any rating within this inspection process. Whilst the evidence is not contributing to the ratings, we have reported on our findings in the report.

We rated Weston General Hospital as requires improvement overall with the urgent and emergency care services rated as inadequate, medicine and older people as requires improvement and surgery and critical care as good.

There had been some progress since our previous inspection with surgery and critical care moving from requires improvement to good overall. In medical care responsive was rated as inadequate with all other key questions rated as requires improvement. However, the ongoing pressures on the emergency department continued to be reflected in the ratings for urgent and emergency care with safety remaining as inadequate and responsive and well led failing to improve also being rated inadequate.

We had serious concerns that systems or processes to manage patient flow through the hospital were not operating effectively and did not ensure care and treatment was being provided in a safe way for service users. We served the Trust with a Section 29A warning notice on 24 March 2017. The notice required the Trust to make the significant improvements by 15 May 2017 in the following areas:

- Systems or processes to manage patient flow through the hospital must operate effectively to ensure care and treatment is being provided in a safe way for patients and to reduce crowding in the emergency department.
- Review the emergency department as the single point of entry to the hospital for both emergency and expected patients to reduce crowding.
- Ensure access to a specialist senior doctor to review patients overnight in the emergency department is timely and does not delay patient admission to wards.
- Ensure the use of the corridor in the emergency department is an appropriate and safe area for patients to receive care and treatment.

Our key findings were as follows:

- We found the trust had been under increasing pressure to manage flow in the hospital for several months and the emergency department was under sustained pressure from an increase in attendances.
- There was a lack of support for the emergency department from the wider hospital services and a lack of trust wide ownership around patient flow. This meant patients were frequently and consistently not able to access services in a timely way and some patients experienced unacceptable waits for some services.
- There was a fragile medical infrastructure in the emergency department with a crucial reliance on

Summary of findings

locum medical staff at consultant and middle grade positions. However, shortly after our on-site inspection a recent partnership with another local acute trust had secured some input for clinical leadership one day a week.

- The corridor area in the emergency department was frequently used when there were more patients than cubicles available. This was not a suitable or safe environment for patients to receive emergency care and treatment, and was not fit for purpose.
- The trust mortality rate had been higher than the expected level for the recent reporting periods of July 2015 to June 2016. A review of mortality and an associated action plan were in place; however, the lack of recorded minutes and actions in speciality mortality review meetings was of concern. It was unclear if learning was shared or action taken as a result of reviews of patient deaths.
- Since our previous inspection there had been some changes to the executive team with some people now in permanent roles and others being interim positions. More changes were due in April 2017 with a new medical director and director of operations starting in post. While the current executives worked well together they had been drawn into managing operational pressures in the emergency department on a regular basis. There was a potential for the two new appointments to lead to a change in approach. In a small trust the pressures on individual executives and senior managers was greater, with many undertaking many roles and holding responsibilities which in a larger team would be more evenly shared. At times this led to extreme pressure on individuals. A review of governance had begun to implement change but was immature and lacking in clinical leadership at directorate level to provide robust assurance.

Safe

- We rated safety as requires improvement overall with safety in urgent and emergency care rated as inadequate, in medicine it was requires improvement and good in surgery and critical care.
- Medical staffing levels and skill mix did not ensure safe care at all times in the emergency department and medical wards. There was a fragile medical infrastructure with a critical reliance on locum medical staff at consultant and middle grade positions.
- In the emergency department there was no clinical lead consultant medical leadership to focus direction and ensure safety was a high priority.
- There were risks to children that medical staff did not have the appropriate skills and capability due to the lower numbers seen of emergency cases of paediatric cardiac arrest or deteriorating child.
- The facilities in the emergency department did not all meet patients' needs and were inappropriate. The corridor area was not a suitable or safe environment for patients to receive emergency care and treatment and was not fit for purpose. This area posed environmental risks and was a poor patient experience.
- There had been little progress in reducing mortality at the trust. While an action plan was in place, progress with some areas was limited and there was a lack of attendance and accountability at the mortality meetings and learning points and actions were not evident in all specialities.
- Trust policy for the management of medicines was not always adhered to, for example checking of controlled drugs, recording of medicine refrigerator temperatures and recording of signatures of agency nurses and locum doctors.
- Pharmacy staffing levels did not meet service, clinical and medicines governance demands and achieve medicines related Commissioning for Quality and Innovation (CQUIN) and Carter model hospital indicators, and therefore protect patient safety.
- Mandatory training compliance required improvement, particularly in basic life support and dementia awareness. With doctors not reaching compliance targets more often than nursing staff.
- We found a fire exit in the stroke unit was blocked and could cause delay of evacuation in the event of a fire. The trust took action when we raised the issue but it continued to be poorly managed and had not been fully rectified on our unannounced visit. This was included on the risk register but not being managed effectively.

However:

- There had been no cases of methicillin-susceptible Staphylococcus aureus (MRSA) in the previous year.
- There were systems and processes in place to reduce the risk of cross infection and clinical areas and wards we visited were visibly clean.

Summary of findings

- Sepsis screening and pathways were in place with early treatment seen to be improving. Within nine months, the number of patients with identified sepsis receiving antibiotics within one hour had increased from 11 % to 78%.
- Staff took a proactive approach to safeguarding and were aware of local safeguarding procedures for both adults and children. Although there were some delays in investigations due to staffing pressures.
- A substantial amount of work had been carried out on National Safety Standards for Invasive Procedures (NatSSIPs). The changes were being embedded in to practice across all surgical departments.
- A prevention and reduction for pressure ulcers action plan had been created in November 2016, the action plan was in its infancy, however, processes were being put in place to improve awareness and ensure safe management of pressure ulcers.
- Staff understood their responsibility to report concerns and incidents. The duty of candour was mostly understood by staff and staff openness and transparency about safety was encouraged.

Effective

- We rated effective as requires improvement overall with urgent and emergency care and medicine and older people rated as requires improvement and surgery and critical care as good.
- The hospital did not have an orthopaedic-geriatric service in line with national guidance due to recruitment problems.
- Not all patients with fractured neck of femurs were operated on within 48 hours of admission, or admitted to an orthopaedic ward within four hours in line with national guidelines.
- When benchmarked against other hospitals the trust performed worse than the England average in a number of national audit programmes including: the 2015 Bowel Cancer Audit where the hospital had a mixed performance compared to other hospitals. The trust scored 'E' for patients being directly admitted to the stroke unit. The heart failure audit for 2015 showed the trust was worse than the England and Wales average for three of the four standards relating to in-hospital care and four of the seven standards relating to discharge. The 2015 National Diabetes Inpatient Audit (NaDIA) scored better than the England average in five metrics and worse than the England average in 12 metrics. Quality improvements were not always sustained and audit findings were not shared and used effectively to improve quality and patient outcomes.
- The inability to recruit senior medical staff led to a lack of clinical leadership and did not provide sufficient support to junior doctors and ensure optimum patient safety at times of increased capacity.
- Multidisciplinary working was not all coordinated to provide effective care for patients. In the emergency department there were professional working relationship breakdowns between doctors and established routines which had not been effectively addressed. These impacted on patients as early speciality review was delayed and patients had to wait in the emergency department.
- A dietician audit identified poor performance for the completion of the malnutrition universal screening tool (MUST) assessments within 24 hours of admission, where the MUST was not always completed accurately.

However:

- Care and treatment was planned in line with current evidence based guidance. Clinical care pathways and toolkits were developed in accordance with national guidelines.
- Patients received effective care in the critical care unit with practices and protocols in line with guidance and patients had the outcomes that should be expected.
- There was an effective stroke pathway in place through the emergency department.
- Patients' consent to care and treatment was sought in line with legislation and guidance. Most staff had a clear understanding of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards and patient consent.
- Patients had their pain assessed regularly and managed promptly to ensure they remained as comfortable as possible.
- Since the last inspection, the hospital had employed a dedicated acute pain nurse in line with the Royal College of Anaesthetists Accreditation Standards.
- There was strong multidisciplinary working across wards and departments.
- The Patient Reporting Outcomes Measures (PROMS) and the National Joint Registry for the period of April

Summary of findings

2015 to March 2016 showed that more patients who had groin hernia operations felt better and fewer patients felt worse after their treatment than the England average.

- The hospital performed well in the 2016 National Emergency Laparotomy Audit (NELA). The hospital achieved a green (>80%) rating for high-risk cases with a consultant surgeon and anaesthetist present in the theatre and of highest-risk cases admitted to critical care post-operatively.

Caring

- Caring was rated as good overall and good for each core service.
- Staff in the emergency department remained professional and compassionate while under considerable pressure in a full to capacity and pressured environment. They were seen to take the time to speak with patients and those close to them in a respectful and considerate way. We saw staff delivering compassionate care and treating patients with kindness, dignity and respect. Privacy and confidentiality was respected as much as was possible considering the constraints of the environment.
- Patients who were delayed in the emergency department received nursing care and support, and were transferred to beds for their comfort and food and drink provided.
- Patients on surgical wards commented on how the care from the nursing staff and allied health professionals was 'superb', 'exemplary 'and staff had a 'great sense of humour'
- In critical care we observed staff treating patients with kindness, warmth and emotional intelligence.

However:

- In critical care the patients' diaries were not being seen as belonging to the patient and were not being given to all patients or their relatives when they left the unit.

Responsive

- Overall, improvements were required to ensure that services within the hospital were responsive to patients' needs. Effective was rated inadequate in urgent and emergency care and medical care and requires improvement in surgery and critical care.
- There was no sense of urgency to respond and promote discharge to initiate flow through the emergency department to the rest of the hospital to reduce crowding in the emergency department. The bed management meetings were not dynamic in ensuring flow of discharges and admissions were acted on by the wider trust and not all required staff attended.
- The emergency department was the single point of entry to the hospital for GP expected patients. There were no direct GP admission pathways in place and this further impacted on crowding in the emergency department on a regular basis.
- Lack of timely access to a specialist senior doctor to review patients overnight in the emergency department was at times leading to delays in patient admission to wards.
- Patients were not able to responsively access the care they needed. The trust did not consistently admit patients within 4 to 12 hours. This meant patients were in the emergency department longer, up to 20 hours and the department was much busier as a result.
- Patient flow within the hospital affected theatre utilisation and cancellation rates. The ambulatory emergency care unit and discharge lounge were underutilised and the medical assessment unit was ineffectively used.
- Medical patients were being cared for on surgical wards. The trust seemed unable to rectify this position and ensure patients received care on the appropriate ward for their speciality.
- The trust did not consistently achieve the national standard for ambulance turnaround times. The trust does not separately measure the time to initial assessment for ambulance cases; this is included in the overall time to initial assessment in the emergency department. The trust consistently performed within the target for the latest 12 months. There had been a recent increase in patients leaving the department without being seen.
- The hospital performed worse than the England average for length of stay in general medicine and surgery. The average length of stay for the trust was 10.1 days compared to the England average of 3.6 days for medical patients and for surgery it was 3 days for

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elective patients, compared to 3.3 days for the England average. For surgical non-elective patients, the average length of stay was 6.3 days, compared to 5.1 days for the England average.

- Too many patients were delayed in their discharge from critical care to a ward. These delays were worse than the national average. Some patients were discharged onto wards at night as a bed had become available, when night time discharge was recognised as less than optimal for patient's wellbeing and mortality.

However:

- Despite the pressures and capacity issues the emergency department took account of patients' specific needs. Individual care needs and adjustments were put in place.
- Dementia was well considered across wards and units and patients were identified using a 'forget me not' magnet. There was an older people's mental health liaison nurse who provided support for patients living with dementia. Staff were positive about this role and felt staff and patients were well supported.
- The trust also employed a complex needs sister and a strategic lead for learning disability services. Staff notified these staff when a person with a learning disability was admitted and the strategic lead would then follow up the patient either in hospital or through discharge.
- The management of meals and support provided to patients during a meal time on Kewstoke ward (care of the elderly) was responsive, where patient individual needs were central.
- The dietetic department had expanded menu choices for those patients on a textured diet and had provided patients with their own specific modified menu so they could specify their own meal choices.

Well led

- Overall leadership at the trust was rated as requires improvement.
- Despite a strategic vision there was a lack of assurance for delivery of the vision as the trust remained reliant on external solutions.
- The lack of progress in securing clinical leadership and a substantive medical workforce in the emergency department had not enabled improvements to the service to meet the needs of patients.
- Some progress had been made since the governance review although there was recognition that further strengthening of directorate governance and board to ward assurance was required.
- The trust was not meeting their contractual obligations under the Workforce Race Equality Standard.
- Progress in reducing hospital mortality was not evident with commitment to sharing and embedding learning from mortality reviews to improve patient outcomes not consistent across services.
- The most recent staff survey results placed the trust in the worse 20% for a number of key areas, some of which reflected lack of progress with current actions.

However:

- The recent partnership working was seen as positive and some early progress for support had been put in place in the emergency department.
- The director of nursing was seen as approachable and providing support to drive nursing in the trust.
- Patient and staff stories were presented to the board and enabled members a better understanding of the challenges faced by staff and where improvements could be made for patient experience.

We saw several areas of good practice including:

- The oncology and haematology department demonstrated outstanding practice with the way they assessed patient risk. Patients with a risk of neutropenic sepsis were easily identifiable through the use of a yellow jacket placed on patient notes.
- Patients living with dementia were situated in the bays or side rooms that were most visible to the nursing station. Staff who provided enhanced supervision to these patients were wearing yellow tabards and were easily identifiable. Staff were allocated to a patient or a group of patients in a bay and were not to be removed unless another staff member had taken over from them. We saw the hospital's own 'This is me' booklet in the notes of a patient living with dementia. This

booklet had been completed by a relative of the patient and explained the patient in detail, what they liked to be called, what they liked to do and what was their favourite food.

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

Importantly, the trust must:

- Ensure that there are sufficient numbers of suitably qualified, competent, skilled and experienced doctors deployed within the hospital. This includes sufficient medical leadership within the emergency department and suitable levels of staff to ensure the corridor is safely staffed.
- Take action to ensure that there are sufficient medical staff with sufficient skills in advanced paediatric life support in the emergency department.
- Take action to ensure that medicine systems in the emergency department are safe for controlled drugs including signature list for agency nursing staff and locum doctors, to cross reference who had prescribed and administered medicines.
- Take action to ensure that systems are in place to ensure patient flow through the hospital was responsive.
- Ensure patients are being admitted promptly once the decision to admit has been made. Take action to ensure that safety checks in the emergency department are completed.
- Take action to ensure that patients are cared for in a safe environment in the emergency department.
- Review the medical staffing and ensure safe levels of medical cover and support to juniors on the medical wards in evenings and weekends.
- Review the use of locum consultants and take action to ensure medical staffing is not vulnerable through recruitment of permanent consultant staff.
- Be assured junior medical staff are being provided with appropriate support and are competent in their roles.
- Ensure safe nursing cover is provided on Cheddar ward and agency usage is kept to a minimum.
- Take action to mitigate risks included on the risk registers effectively, reviewing regularly and managing those risks identified on a timely basis to ensure safety to staff or patients is not compromised.
- Manage quality and performance and ensure sustained learning and improvements from audits.
- Take action to continually maintain a clear path for evacuation in the event of a fire within the stroke unit by ensuring fire exits are not blocked.
- Take action to ensure patient flow from the emergency department through the medical wards to timely discharge is effective and timely in meeting the needs of patents, and ensuring good quality care and treatment.
- Take action to address areas of concern and demonstrate patient outcomes monitored by the Summary Hospital – level Mortality Indicator (SHMI) are improved.
- Improve the quality, attendance, accountability learning points and actions from mortality and morbidity reviews in all specialities.
- Make sure the surgical directorate has an orthopaedic-geriatric service for pre and post-operative care.
- Ensure all patients that had fractured neck of femurs were operated on in line with national guidelines and admitted to an orthopaedic ward within four hours.
- Follow trust policy for the management of medicines, for example checking of controlled drugs, recording of medicine refrigerator temperatures and recording of signatures of agency nurses and locum doctors. (Accident and Emergency)
- Review pharmacy staffing levels in order to meet service, clinical and medicines governance demands and achieve medicines related CQUINS and Carter model hospital indicators, and therefore protect patient safety.
- Ensure multidisciplinary input and a collective approach to the running of the critical care unit. The medical team leaders must ensure they meet regularly with the senior nursing leadership to provide a multi-professional approach and contribution to all aspects of running the unit, including governance and provision of quality care.
- Address the poor access and flow of patients in critical care in order to reduce the delays to patients who are fit to leave the unit, reduce the risks of patients not having timely admittance, eliminate breaches in same-sex rules, stop the relocation to or delay of patients in the operating theatre recovery area, and reduce the number of patients who are transferred to a ward bed at night.

Summary of findings

- Produce mortality and morbidity reviews for critical care where there is accountability for learning and change, and a demonstration as to how this has improved practice and safety.
- Review the provision for and quality of life support training in the trust to ensure there are a satisfactory number of staff with the right experience and training on duty at all times.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Weston Area Health NHS Trust

Weston Area Health NHS Trust provides acute hospital services and specialist community children's services to a population of 202,566 people (source: 2011 census), 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.

It has three locations that are registered with the Care Quality Commission. These are Weston General Hospital, The Barn in Clevedon and Drove House which both provide special community children's services.

Deprivation is not compared to the England average in the 2016 Health profile; however, life expectancy is 9.1 years lower for men and 6.5 years lower for women in the most deprived areas of North Somerset in and around the coastal areas.

According to the last census in 2011 97.3% of the population of North Somerset was white with the Black and Ethnic Minority Group accounting for 2.7% of the population. 51.4% of the population is female and 48.6% is male.

The trust has a total of 270 beds spread across various core services (265 general and acute beds and five critical care).

Our inspection team

Our inspection team was led by:

Chair: Professor Edward Baker, Deputy Chief Inspector, Care Quality Commission

Head of Hospital Inspections: Mary Cridge, Care Quality Commission

The team included CQC inspectors, a CQC Director of People, a CQC pharmacist and a variety of specialists including: accident and emergency nurse; accident and emergency consultant; accident and emergency doctor; medical nurse; medical doctor; theatre nurse; surgical doctor; surgery nurse; critical care nurse; critical care doctor; Director of Nursing; Medical Director and one expert by experience.

How we carried out this inspection

We carried out the announced part of our inspection between 28 February and 2 March 2017 and returned to visit some wards and departments unannounced on 9, 10, 13 and 14 March 2017.

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

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

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

Summary of findings

What people who use the trust's services say

We spoke with approximately 50 patients during our inspection across all services. Feedback was generally positive with patients telling us staff treated them with dignity and respect and they were all very comfortable with the level of care.

Patients recognised staff were under pressure at times telling us 'all the staff do an amazing job with the pressures they are under'. One patient told us how a porter was 'jovial and sensitive to my needs' during a delayed scan appointment. On the day case unit a number of patients praised the hospital and the care they received.

Relatives were included in care and said they felt there was a high standard of compassion among all the nurses and doctors. They recognised the anxieties the families had and tried to reassure them all the time. One relative told us "I can't find the words to express their kindness to all of us."

In the Friends and Family test for medical wards there was a 36% response rate between December 2015 and November 2016, which was better than the England average of 25%. The results for three months positively showed patients would recommend their friends and family; November 2016 98%, October 2016 93% and September 2016 96%. In surgery response rates were also better than the England average with the day case unit scoring 96-100%, the lowest score had been 75% on Steepholme for one month.

Facts and data about this trust

Weston Area Health NHS Trust provides acute hospital services and specialist community children's services to a population of 202,566 people (source: 2011 census), 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.

It has three locations that are registered with the Care Quality Commission. These are Weston General Hospital, The Barn in Clevedon and Drove House which both provide special community children's services.

Deprivation is not compared to the England average in the 2016 Health profile; however, life expectancy is 9.1 years lower for men and 6.5 years lower for women in the most deprived areas of North Somerset in and around the coastal areas with 40% of the local population living in poverty.

According to the last census in 2011 97.3% of the population of North Somerset was white with the Black and Ethnic Minority Group accounting for 2.7% of the population. 51.4% of the population is female and 48.6% is male.

The trust has a total of 270 beds spread across various core services (265 general and acute beds and five critical care).

NHS North Somerset Clinical Commissioning Group is the trust's main commissioner accounting for approximately 69% of trust healthcare income, with NHS Somerset accounting for circa 16% of income. In addition, the trust receives other non-patient related income including education and training monies.

The Board of Directors comprises the Trust Chairman, five independent Non-Executive Directors and five voting Executive Directors: the Chief Executive, the Deputy Chief Executive and Director of Finance, the Medical Director, the Director of Nursing, and the Director of Strategic Development. There are also two non-voting executive directors: the Operations Director, and the Director of Human Resources.

We inspected this trust as part of our in-depth hospital inspection programme in May 2015.

We rated the trust as requires improvement overall. Medical care was rated as inadequate, urgent and emergency care, critical care and surgery were rated as

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requiring improvement and maternity and gynaecology , services for children and young people, outpatients and diagnostic imaging and end of life care were all rated as good.

We carried out a focused unannounced inspection in August 2015. This was to follow up on concerns raised about medical staffing and the support provided to junior doctors in the trust.

Weston Area Health NHS Trust has had a total of 13 inspections since registration. Eleven of these have been at Weston General Hospital. There were significant concerns found at the inspection in April 2013 when we found patient's privacy and dignity were not always respected and the welfare and safety of patients was not always ensured. As a result we took enforcement action to protect the health, safety and welfare of people using this service.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? **We rated safe as requires improvement overall because:** • Medical staffing in medicine and the emergency department did not ensure safe care at all times. There was a limited, fragile medical infrastructure which had a critical reliance on locums to cover vacancy gaps in middle level and registrar doctors. • The lack of senior medical leadership in the directorates was of concern. There were difficulties in attracting staff to senior medical roles within the trust. Despite recruitment campaigns and rotational contracts being available the trust appeared unable to attract and secure sufficient doctors to fill the posts. • The trust was an outlier for mortality data which lacked sufficient senior medical staff and effective clinical engagement to progress and improve outcomes. Mortality and morbidity meetings were not well attended and learning was not shared. • Staff had a variable understanding of duty of candour, medical staff were aware, however nursing staff had an inconsistent knowledge. • There was not sufficient occupational therapy and physiotherapy staff to meet the needs of patients on the medical wards and the stroke unit. • The pharmacy team were unable to provide a seven day pharmacy service due to a lack of investment. They were unable to achieve the levels of medicines reconciliation within 24 hours as laid down in National Institute for Health and Care Excellence (NICE) quality standard 120. • There was no regular use of the medicines safety thermometer which was not in line with trust policy for monthly recording. However: • There was a good incident reporting culture and they were actively encouraged to complete electronic incident reports. Staff were aware of their responsibility to report incidents and received learning from incident investigation through daily handovers and feedback through safety briefings and bulletins. • Nursing staffing levels were in line with the hospitals staffing measurement tool, with a regular reliance on agency staff when required to cover increased demand and vacancies. **Duty of Candour**	**Requires improvement** 

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation introduced in November 2014. This Regulation requires the trust to notify the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. When things went wrong, patients were provided with a timely apology and support as needed. We spoke to staff in various roles and found understanding of duty of candour was variable, medical staff were aware, however nursing staff had an inconsistent knowledge. Staff were unaware of the trust providing any training or support for the duty of candour. Duty of candour was referred to in the trust's policy for incident investigations, and the content of the policy met the legal duties on staff to adhere to this requirement.

Safeguarding

- The trust lead for safeguarding had a focus on training for safeguarding with compliance being at 90%. However, uptake of the training was less good for medical staff.
- Knowledge of how to report safeguarding was good, although there had been a recent case where there was a delay, possibly attributed to agency staff.
- Investigations into safeguarding incidents were led by ward managers with the safeguarding lead being notified of any incidents that were logged on the incident reporting systems. However, there were concerns about the length of time taken for investigations to be completed. This was mainly felt to be due to operational pressures and staff not being able to set aside time.
- The safeguarding adults' policy had been implemented in accordance with national guidelines being updated in 2016 to take account of the statutory requirements of the Care Act (2014) which had superseded the government's 'No Secrets' paper of 2000. The children, young people, and unborn babies' policy had been updated in 2014 to take account of the Working Together to Safeguard Children 2013 guidelines. The policies provided definitions of abuse, including references to modern slavery, and guidance about the meaning of neglect and acts of omission.
- The emergency department risk register identified as a high risk that when paediatric patients present to the Emergency Department, processes in place to safeguard them were not always adhered to. An action plan was in place to address the risk. We spoke with staff who explained the process to follow;

the recording process and the secondary follow up by paediatricians from the day unit daily to ensure that all children seen the day before had been reviewed. We were assured by a consultant that all children seen were discussed with a consultant before they left the department.
- A bi-monthly newsletter called 'The Safeguard' which covered adults and children gave staff access to updates, new legislation, advice and shared topical issues relevant to safeguarding adults and children.

Incidents

- People were protected from abuse and avoidable harm. Lessons were learned and improvements were made when things went wrong. There were systems, processes and practices in place to keep people safe, and these systems and processes were communicated to staff.
- An incident policy reflected current guidance for reporting and investigation, with processes in place for 72 hour and root cause analysis investigations. Review of a number of investigations demonstrated detailed review with relevant staff being involved. Many investigations had an accompanying action plan with clear actions and assigned to appropriate staff.
- Nursing and medical staff across all areas visited felt there was a good incident reporting culture and they were actively encouraged to complete electronic incident reports. Staff were aware of their responsibility to report incidents and received learning from incident investigation through daily handovers and feedback through safety briefings and bulletins.
- There was learning and action from incidents with an example relating to pressure ulcers which was the most reported serious incident in the trust. Mirrors had been given to all staff to aid their assessment of skin damage and staff told us these were frequently used.
- We attended a hospital wide senior nurse meeting and observed how actions from incidents were identified, and disseminated to the senior ward leaders and dates were set for those actions to be completed. It was clear that the hospital was focussing on a change of attitude across all departments to pressure damage.
- No never events had been reported for the emergency department, critical care or surgery in the last year. 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.

Summary of findings

- A never event was reported for the medical care service in February 2017. A guide wire was not removed following a chest drain insertion. Action was taken by the trust to review the equipment being used and disseminated safety checklist posters to remind clinicians to complete the checklist for all invasive procedures. During our inspection staff across all wards were aware of this event and the learning which resulted.
- Since our last inspection a 'hazard' telephone line had been set up to encourage doctors to report any concerns as it had been recognised they were not always reporting incidents via the incident system as this was time consuming and would identify the reporter. The line was anonymous and had appeared to be successful as a range of incidents were reported. Doctors we spoke with reported this as a positive message from the hospital that their concerns were being listened to. Concerns reported on were followed up and an example of this related to hazard phone calls which had identified a number of omitted Parkinson's medication. This had suggested a lack of staff awareness and the pharmacy team were looking at developing a project to raise staff awareness. A monthly newsletter on items reported was sent to staff. Staff were aware of their responsibilities to still electronically report incidents in line with the trust's procedure for incidents involving patient harm or near misses. The hazard line was anonymous and therefore tracking and investigation of incidents reported was at times difficult.
- Oversight of the hazard line was by the governance and risk team who collated themes and any that met incident criteria were added as an incident. Any hot spots or themes were reported to the executives.
- The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at trust level across the NHS in England. This indicator is produced and published quarterly as an official statistic by the Health and Social Care Information Centre (HSCIC) with the first publication in October 2011. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It includes deaths in the hospital and those that occur outside of the hospital within 30 days of discharge. Data for October 2015 to September 2016 (published in March 2017) showed that the trust had a higher than expected level. The latest data showed

actual deaths of 1,007 against an expected number of 875. There had also been little improvement between this data set and the previous one, which covered July 2015 to June 2016 (released in December 2016).

- There was a theme across several specialities that the morbidity and mortality meetings were not well attended or held regularly and therefore learning was not being shared or discussed effectively to impact on patient outcomes. The trust had an action plan led by the medical director which identified seven quality improvement projects aimed at reducing mortality. These included urinary tract infections, fractured neck of femur and sepsis recognition and management, lack of sufficient senior medical staff and poor clinical engagement, and were recognised as barriers to progress and improved outcomes in all areas.

Staffing

- Staffing rotas demonstrated nursing staffing levels were in line with the hospitals staffing measurement tool, with agency staff used when required to cover increased demand and vacancies. Medical staffing in medicine and the emergency department did not ensure safe care at all times. There was a limited, fragile medical infrastructure which had a critical reliance on locums to cover vacancy gaps in middle level and registrar doctors.
- The hospital used the Shelford Safer Nursing Care Tool to calculate staffing levels. The Safer Nursing Care Tool has been developed to help NHS hospital staff measure patient acuity and / or dependency to inform evidence-based decision making on staffing and workforce. The emergency department used a scoring system for acuity and dependency. The tool was used daily to review staffing levels based on the needs of the patients in the department and on wards. Many areas in the hospital were dependent on agency or bank staff to meet planned staffing levels. The medical division had a vacancy level of 28.52 whole time equivalent (WTE) which was a 12.43% vacancy rate and turnover was at 9.27%. The use of agency staff was an area of concern when speaking to staff. The emergency directorate agency usage between February 2016 and January 2017 was at 8.35%. Agency use had increased over the summer months and continued to remain high in to the winter. In the four month period August to November 2016 there were 166.5 WTE bank or agency registered nurses and 174.94 WTE bank or agency unregistered staff used to ensure staffing was as planned.
- Ensuring adequate cover for the emergency department and the corridor represented a fragile situation which placed staff

under pressure and could impact on the safety and welfare of patients. This was particularly evident where the planned levels of nurse staffing and the actual levels varied depending on whether there was an increased demand on a shift. There was often increased overnight staffing levels which included planning for staffing the corridor, even when this was not in use. However, during our unannounced inspection we saw that even when the corridor was not in use, all staff were busy with the high dependency of patients in the department so should the corridor have been in use, further staff would have been needed to ensure a safe level of staffing. Agency staff were working in the department every day and on the 10 March 2017, of the 11 nursing and health care assistant staff on duty, four were agency staff. They told us they had received a full induction and liked working in the emergency department as the team was supportive and welcoming.

- We saw the staffing on Cheddar ward was an area of risk and had been added to the directorate risk register, although there was no date to determine when this was added. Cheddar ward was initially opened as an escalation ward in August 206. In September 2016 the ward was converted to a substantive ward with 20 beds and six escalation beds used at times of escalation. Recruitment for Cheddar ward was ongoing and had been advertised since October 2016. There were 13.97 WTE vacancies a 53.97% rate. During our inspection there was a high use of agency staff on many shifts on Cheddar ward. We spoke to one agency nurse who had been inducted to the ward before their shift. They felt well supported by nursing and medical staff and had no concerns on the ward. They commented how there were good care plans and safety briefings.
- There were safe nursing staff levels in critical care in line with professional standards, although one area of concern related to nursing skills. Nursing numbers were in accordance with the NHS Joint Standards Committee (2013) Core Standards for Intensive Care. Therefore, patients assessed as needing intensive care (described as level three) were cared for by one nurse looking after that one patient at all times. High dependency patients, (described as level two), were cared for by one nurse looking after two patients. The nursing rotas demonstrated meeting this nursing ratio, although with an occasional shortfall due usually to the failure to secure an agency nurse. However, the supernumerary staff did not meet recommended levels. The Faculty of Intensive Care Medicine

Core (FICM) Standard 1.2.5 stated the unit, with 5 beds, should have one supernumerary registered nurse on duty at all times. There was, however, not always one supernumerary nurse in the establishment numbers for each shift.

- There was not sufficient occupational therapy and physiotherapy staff to meet the needs of patients on the medical wards and the stroke unit. According to an internal report submitted in February 2017, the trust employed 0.21 whole time equivalent (WTE) physiotherapists per five beds compared to 1.0 WTE physiotherapist per five beds as recommended by the British Society of Rehabilitation Medicine Standards of Rehabilitation Services 2009. For stroke physiotherapy, the trust employed 0.38 WTE physiotherapists per five beds compared to the recommended level of 0.81 WTE physiotherapists per five beds as stated in the Royal College of Physicians National Clinical Guideline for Stroke (2016). The skill mix of the physiotherapy team also differed to the national average with less band seven therapists and proportionately more band three therapy assistants. Similar staffing challenges were experienced by the occupational therapy teams. A business case for more physiotherapy and occupational therapy staffing had been submitted in 2015 but staffing concerns had not been resolved. The current therapy manager was in the process of compiling a subsequent business case for more staffing.
- Arrangements for nursing handovers and shift changes ensured people were safe. We observed handovers on different wards and departments. The nurse in charge led the handover which began with a comprehensive safety briefing incorporating any risks of patients on the ward. A detailed handover sheet was used detailing patient information and risks. Following the safety briefing patients were handed over at the patient bedside. In the emergency department all actions taken as a result were recorded to ensure an audit trail and any important outcomes were cascaded to all staff.
- Medical staffing did not ensure safe care at all times. There was a limited, fragile medical infrastructure which had a critical reliance on locums to cover vacancy gaps in middle level and registrar doctors. Junior doctors had been removed from the emergency department during night since April 2016. The risks associated with the lack of medical staff were noted as a high risk on the emergency department risk register. Junior doctors across the hospital commented on the high workloads and pressures working within the trust. Support received was of

variable degree and quality. Some junior doctors found this situation stressful and felt out of their depth whilst others thrived in the environment and said it provided them with vast amounts of experience.

- There were only four permanent consultants in post on the medical wards and cover was regularly filled by locums or newly experienced staff. For example Uphill, Kewstoke and Draycott had no substantive consultant post. The use of medical locums in the emergency directorate between February 2016 and January 2017 averaged 8.35%.
- There were difficulties in attracting staff to senior medical roles within the trust. We were told there were recruitment campaigns and rotational contracts available. However, the trust appeared unable to attract and secure sufficient doctors to fill the posts. This impacted on leadership particularly in the emergency department where the clinical lead post has been a vacant post since 2015. The matron was currently responsible for both nursing and medical leadership a role which was not possible for one person to undertake effectively.
- The Royal College of Emergency Medicine (RCEM) has a minimum recommendation of cover for 16 hours emergency consultant hours seven days per week. The rotas showed there were between two and six emergency department consultants on duty throughout the day depending on the time of day. This equated to almost 16 hours per day. Consultant cover was available in the department until 11pm each day. There was then a consultant on call for advice and available to be called in. The department was staffed by locums, middle grade and senior house officer doctors overnight. There were also insufficient permanent middle grade medical staff employed in the emergency department. There were currently 2.7 whole time equivalent staff (WTE)employed which was going to drop to 2.4 WTE.
- In response to the lack of clinical leadership and shortfall in medical staff, in the emergency department, Operation Seagull had been developed. This would be instigated in response to a threat of a short notice closure of the department due to lack of sufficient medical staff on duty. The trigger for considering a closure of the emergency department would be less than two appropriately qualified doctors being on duty with the appropriate level of supervision according to grade. The plan set out the command and control arrangements leading up to a short notice closure, including escalation, cascade and actions required to ensure a joint planned system response to a short notice closure of the Weston emergency department. The trust considered that given current rostering, this presented a risk

overnight and at weekends only. We are aware that over the recent Christmas holiday period this action was close to being triggered. At the time of inspection the covering of night shifts was problematic, with the three days of the following week not yet covered. The medical director explained that the middle grade doctors all had to have the sufficient skills and experience and had to have been trained to advanced paediatric life support training before considered for the shift.

Medicines

- At our previous inspection we were concerned at a lack of investment in pharmacy staff and found this was still the case. The service had an in-house pharmacy service which provided a supply function and a clinical pharmacy service. They provided medicines for in-patient use and discharge medicines. There was an on-site community pharmacy which dispensed out-patient prescriptions and also medicines for patients using accident and emergency and the surgical, medical and oncology day units.
- The pharmacy risk register noted that the pharmacy workforce was not sufficient to cover service, clinical and medicines governance demands and achieve medicines related Commissioning for Quality and Innovation (CQUIN) and Carter model hospital indicators. Carter model hospital modelling calculates that 44 whole time equivalent (WTE) staff were required to achieve pharmacy targets set by group. Current funded establishment was 19 WTE. The current staffing levels meant that the medicines team were unable to provide a seven day pharmacy service or achieve the levels of medicines reconciliation within 24 hours as laid down in National Institute for Health and Care Excellence (NICE) quality standard 120. They achieved 67% against a target of 100% for October 2015 to September 2016.The trust had set itself a target of reconciling medicines for 80% of patients admitted from Monday to Friday. Current data from the trust states that they achieved 88% for patients admitted from Sunday to Friday where medicines were reconciled from Monday to Friday and they were unable to review all in-patient prescription charts on a daily basis.
- The pharmacy service had not audited the pharmacy service against the Royal Pharmaceutical Society standards for hospital pharmacy.
- The discharge process had been reviewed and measures put in place to reduce the time needed to dispense discharge medicines.
- On all the wards visited medicines were stored safely in locked cupboards. The date of opening of liquid medicines were not

recorded, therefore, when the expiry date of the medicine needed to be reduced it was not possible to determine whether these liquid medicines were suitable for use. The in-use expiry date of glucagon injection had not always been recorded when it was removed from refrigerated storage, therefore, it was not possible to state if this medicine was suitable for use.

- The recording of medicine fridge temperatures was completed daily except in accident and emergency; the clinic room temperatures were not recorded in line with trust policy.
- Controlled drugs were stored securely. The access to the cupboard keys was only by authorised staff. Daily and weekly controlled drug checks were completed in line with trust policy except in accident and emergency; this had been noted in the three monthly controlled drug management audit.
- Audits were carried out of medicines storage. The trust's policy was that the medicines safety thermometer was completed monthly for all in-patient units. This included information about the completion of allergy status of patients, the level of medicines reconciliation and the number of omitted medicines. However, a number of wards were not completing the dashboard on a regular basis. This had been noted by the Medicines Optimisation Group and reminders sent to those wards who were not completing the data set.
- Pharmacy provided overview of governance for medicines, including reviewing of medicine incidents, pharmacist interventions and prescribing.
- There was an open culture for reporting medicines incidents, these were investigated and were reported to the medicines management optimisation group. Learning from incidents was identified and the information disseminated across the organisation.

Are services at this trust effective?

Requires improvement

We rated effective as requires improvement overall because:

- Performance in some national audits including the Royal College of Medicine (RCEM) audits, and the Sentinel Stroke National Audit Programme (SSNAP) was poor.
- Medical practice did not adhere to the Academy of Royal Colleges seven day consultant present care standards.
- Not all teams consistently adhered to evidence based guidelines from the National Institute for Health and Care

Excellence (NICE); however insufficient therapy cover impacted upon teams compliance with NICE guidelines around stroke rehabilitation and the provision of rehabilitation prescriptions for patients transferred from critical care to another ward.
- Pathways were not always in place to optimise the effectiveness of patient journey. In the emergency department there were no direct admission pathways to assessment units, or early transition pathways for oncology patients. There was also no frailty pathway in place.

However,

- Results were within the expected range for audits including the national joint registry (NJR) and the Intensive Care National Audit and Research Centre (ICNARC) plus the National Emergency Laparotomy Audit (NELA), Patient related Outcome Measures (PROMS), the bowel cancer national audit and the time from onset of stroke to thrombosis for stroke patients.
- All staff were aware of the importance of prevention and management of sepsis. There was a sepsis pathway used by all the core services we inspected.
- Care was provided in line with National Institute for Health and Care Excellence (NICE) clinical guidelines CG50, recognition of the deteriorating patient. All core services followed best practice with regards to the use of the National Early Warning System (NEWS).
- There was good multidisciplinary working within teams and we saw that staff liaised with specialist nurses and other teams for advice and support to meet the needs of patients
- Staff understood their responsibilities around consent and the Mental Capacity Act. Although understanding of the deprivation of liberty safeguards was less clear, staff knew how to contact the safeguarding lead for advice and guidance.

Evidence based care and treatment

- We saw that, in some specialties, opportunities had not been taken to optimise the effectiveness of the patient journey. In the emergency department there were no direct admission pathways to assessment units, or early transition pathways for oncology patients. Emergency department doctors could not refer patients to the chest pain pathway unless the patient had been formally assessed by the medical team and this slowed down the patient journey. There was no frailty pathway in place which meant that some elderly patients with multiple

diagnoses might not have the holistic assessment required to address their needs. However, there was an evidence based stroke care pathway through the emergency department which ensured patients received effective treatment in a timely way.

- We saw that, in some instances, teams did not consistently adhere to evidence based guidelines issued by the National Institute for Health and Care Excellence (NICE). In critical care, teams did not adhere to NICE guidance 83: 'Rehabilitation after critical illness' as patients were not given a rehabilitation prescription upon discharge from the unit. This meant that their on-going rehabilitation needs were not communicated as effectively as possible. In medicine, therapy services were unable to provide recommended levels of rehabilitation for stroke patients as detailed in NICE guidance CG162 'Stroke rehabilitation in Adults'.
- In medicine, practice did not adhere to the Academy of Royal Colleges seven day consultant presence care standards because patients were not reviewed during a consultant delivered ward round at least once every 24 hours unless acutely unwell.
- 'Care bundles' had been developed that incorporated best practice for several of the high risk conditions that patients might present with including falls, respiratory care and pressure ulcer care. These care bundles guided staff to select effective interventions that were proven to be helpful to patients in managing their condition or preventing deterioration. National Safety Standards for Invasive Procedures (NatSSIPS) were used to guide clinicians in best practice for invasive procedures such as insertion of chest drains, insertion of central lines and tracheostomies.
- There were good examples of teams following best practice that took account of evidence based guidelines issued by the National Institute for Health and Care Excellence (NICE). We saw evidence of this in the critical care service with regards to the management of sedation, in the medicine service in regards to the management of diabetes and in the surgery service with regards to the prevention and management of falls. In the emergency department, teams used a combination of National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines to determine the treatment provided.
- All staff were aware of the importance of prevention and management of sepsis. There was a sepsis pathway used by all the core services we inspected which was adapted from National Institute for Health and Care Excellence (NICE)

guidelines. Sepsis was audited as part of the hospitals Commissioning for Quality and Innovation (CQUIN) programme and this had been achieved in the nine months preceding our inspection.

- We saw the safe handover of patients from theatres to recovery and recovery to the wards. The theatre manager had implemented a standardised approach to handover using the Situation, Background, Assessment and Recommendation communication tool. This tool ensured an effective and efficient way to communicate important information as recommended by the Institute for Healthcare Improvement.
- Care was provided in line with National Institute for Health and Care Excellence (NICE)clinical guidelines CG50, recognition of the deteriorating patient. All core services followed best practice with regards to the use of the National Early Warning System (NEWS). This system allocated a score to patient's physiological measurements whilst they were being monitored in the hospital. The hospital carried out an annual audit for compliance in escalation of patient care using the NEWS scoring system.

Patient outcomes

- We saw that the hospital staff participated in national audits which indicated varied performance across specialties.
- Readmission rates for all core services were within the expected range and lower than the national average (i.e. better) for patients on the medical wards.
- Mortality rates were within the expected range for most patient groups, however, the Summary Hospital-level Mortality Indicator (SHMI) indicated a higher than expected mortality rate for patients who had a fractured neck of femur which had been evident in data since July 2015. The hospital planned to re-introduce an orthopaedic geriatric service but this had not progressed at the time of our inspection.
- Results were within the expected range for several national audits including those conducted by the national joint registry (NJR) and the Intensive Care National Audit and Research Centre (ICNARC) plus the National Emergency Laparotomy Audit (NELA), Patient related Outcome Measures (PROMS), the bowel cancer national audit, the Oesophago-Gastric Cancer National Audit (OGCNA), and the time from onset of stroke to thrombosis for stroke patients.

- In critical care, the service contributed towards the ICNARC and this indicated that the service was performing within the expected range and met the Faculty of Intensive Care Medicine (FICM) core standards. We saw that the rate of transfer to other units were lower (i.e. better) than the national average.
- However, performance in some other national audits was less favourable. In the emergency department there was mixed performance in the most recent Royal College of Emergency Medicine (RCEM) audits. Of most concern were the lowest scoring metrics which included: consultant discussed treatment with patient, antibiotics administered within one hour, actively checking and documenting blood glucose in children fitting on arrival, patients assessed by mental health professional within one hour and their needs documented.
- For surgical patients, the EQVAS hip replacement indicator showed that fewer patients were happy with their outcomes following hip replacement surgery than the national average. However, the hospital achieved good outcomes with regards to the length of stay for patients with hip and knee joint replacements which in 2014 to 2015 were less than or similar to the national average.
- In medicine, improvements to the Sentinel Stroke National Audit Programme (SSNAP) score were not sustained and at the time of our inspection the trust's score had declined to level D. The programme sets out the standard for patients to go to a stroke unit as their first ward within four hours of arrival to hospital. However, data showed this was not the case for a high proportion of stroke patients at the hospital.
- The hospital performance assurance framework (PAF) data collection from May 2015 to November 2016 showed a steady decline in compliance to the venous thromboembolism or blood clots (VTE) assessment tool.
- In some specialties, we saw that improvements had been made following underperformance in national audits. For example, in surgery, performance in the hip fracture database showed some improvement although results continued to be mixed. Poor performance in the 2015 National Diabetes audit had led to changes in practice which had resulted in improvements in the management of hypoglycaemia and a reduction in medication prescribing errors.

Multidisciplinary working

- Staff we spoke with told us that within teams, staff worked well together and we saw evidence of this in all wards and

departments. For example, therapy staff in the surgery service were developing training for ward staff to enable them to continue patient's rehabilitation programmes at weekends and evenings.

- Specialist nurses were seen working well with staff and patients in all the core services we inspected. Staff spoke highly of the critical care outreach team that worked with staff on the wards to manage deteriorating patients. In the emergency department, we saw this team working effectively with the intensive care team. Volunteers supported multidisciplinary teams on surgical and medical wards, providing companionship for patients and helping with meal times.
- All staff we spoke with were familiar with the process to refer patients to specialist support services if required, such as the mental health service, alcohol and drug misuse service, dementia and learning disability. There were good working relationships with the ambulance service and community services such as community nurse teams and GPs.
- The mental health liaison team provided support to patients and had worked with the emergency department to develop guidelines to ensure they were able to meet the needs of frequent attenders with mental health issues.
- However, there were barriers to effective multidisciplinary working between the emergency department teams and the medical teams. In the emergency department, patients waited until after 9am for medical specialty doctors to assess them to facilitate their transfer to the specialty ward. This caused delays to the patient journey.
- We saw that discharge plans were commenced on day one of the patient's admission to hospital, and in surgery this was even sooner, at the pre-admission clinic. Staff tried to anticipate all the patient's needs prior to their discharge. This involved comprehensive discussions at multidisciplinary meetings attended by all relevant staff.
- We saw that regular board meetings took place on wards where patient's medical needs were discussed. However, on medical wards consultants rarely attended these meetings which impacted upon the medical senior leadership of individual patients.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Compliance with training for mental capacity and deprivation of liberty safeguards was 69%. This was reported to be due to the difficulties in staff being able to attend, often due to

operational pressures on the wards over the previous few months. Training for medical staff will be part of their essential training days with 90 minute sessions in May and September this year.

- Staff demonstrated a clear understanding of the requirement to gain patient consent. Patients' consent to care and treatment was sought in line with legislation and guidance. For example, in surgery written consent was completed pre-operatively in the outpatient clinic and verbally checked again on admission and as part of the World Health Organisation (WHO) safe site surgery checklist. Patients and their relatives/carers living with dementia, learning disabilities, autism or mental health issues were given extra time during the pre-admission process to make sure the correct consent was obtained.
- There was a trust 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. This included the rationale behind the decision, together with a review date and any other relevant comments concerning the patient's individual circumstances. A copy of the DNACPR order was placed on the patient's case notes; it was the first document that was seen.
- Staff had a clear understanding of the Mental Capacity Act 2005 (MCA). Staff knew they were required to act in the best interests of patients who were unable to make valid choices. We saw in patient records that staff clearly documented when patients refused treatment. For patients who lacked the mental capacity to make their own decisions, assessments of capacity were undertaken by nursing and medical staff. Once completed, decisions taken in the patient's best interest were clearly documented in each patient's records.
- In critical care, staff showed a varied understanding of Deprivation of Liberty Safeguards (DoLS). However, staff felt comfortable to contact the safeguarding lead for advice and direction when they were unsure.
- There was a trust policy and protocols for the safe and appropriate use of restraint which was recognised as a deprivation of a patient's liberty in certain circumstances. Staff in critical care told us the use of restraint would be used when it became part of their duty of care to protect the patient and when alternatives had been tried and were unsuccessful. This would be to prevent the patient from injuring themselves or

others, or potentially limiting their own treatment and recovery and might include use of medicines to calm patients or use of hand mitts to prevent a patient trying to remove lines, masks and breathing aids.
- Staff on the medical older persons ward were aware of the need to involve independent mental capacity advocates for patients who required deprivation of liberty safeguards (DoLS). Nurses referred patients to an external team to complete applications for deprivation of liberty safeguards and this team arranged independent mental capacity advocates (IMCA) when necessary. However, the safeguarding lead was not assured that this occurred consistently.

Are services at this trust caring?

Good

We rated caring as good overall because:

- Privacy and dignity was always maintained and respected.
- Staff were responsive to patient communication needs and different methods were used to ensure the understanding of patients.
- The trust's Urgent and Emergency Care Friends and Family Test performance was generally better than the England average for most of last year and a dip in scores had since levelled out.
- When patients were delayed in the emergency department, they were transferred to beds for their comfort and food and drink provided. Nursing staff then maintained care until transfer could be agreed.
- Results of the friends and family tests and patient satisfaction feedback were positive in many services with scores around 96 –98%.
- Patients, their family or friends were involved with decision-making. They were able to ask questions and raise anxieties and concerns. They were given answers and information they could understand.
- We observed staff treating patients with kindness, warmth and emotional intelligence.

However:

- A number of patients commented on how dissatisfied they were with the communication from staff including doctors and receptionists and the waits and delays they experienced.
- During nurse to nurse handovers patients were not always acknowledged.

- Access to support services, psychological input and counselling was not readily available internally, however there were examples of patients being helped to access these services through external referral.
- On the critical care unit patients' diaries were not being seen as belonging to the patient and were not being given to all patients or their relatives when they left the unit.

Compassionate care

- Despite the difficulties of a very busy emergency department staff took the time to speak with patients and those close to them in a respectful and considerate way. We saw staff delivering compassionate care and treating patients with kindness, dignity and respect. We spoke with five patients and two relatives who told us staff were kind and caring and they had been updated about any changes or delays. One patient told us that despite the staff being very busy they had all been wonderful.
- When patients were delayed in the department, they were transferred to beds for their comfort and food and drink provided. We saw volunteer staff proving drinks to patients and relatives having checked first with staff that this was appropriate.
- The trust's Urgent and Emergency Care Friends and Family Test performance was generally better than the England average between December 2015 and November 2016. In latest period, November 2016 trust performance was 79% compared to an England average of 86%. The recent trend from July 2016 to October 2016 has been getting worse although it did level out in November 2016. For medical wards there was a 36% response rate between December 2015 and November 2016, which was better than the England average of 25%. The results for three months positively showed patients would recommend their friends and family; November 2016 98%, October 2016 93% and September 2016 96%. In surgery response rates were also better than the England average with the day case unit scoring 96-100%, the lowest score had been 75% on Steepholme for one month.
- Inpatients were asked to complete an 'exit questionnaire' rating their experience of care between one (being the worst) to five (being the best experience). We reviewed the July to September 2016 quarterly exit card results report, this showed a number of positive comments about the care provided by staff. However, a number of patients commented on how dissatisfied they were with the communication from staff including doctors and receptionists and the waits and delays they experienced.

Summary of findings

- Annual patient satisfaction surveys for endoscopy and oncology and haematology were overall very positive. 96% of patients said the courtesy of the nurse who prepared them for the test was good and 92% felt the amount of information given to them by the nurse was good. 95% and 98% of patients said they were given enough privacy and felt there privacy and dignity was respected in endoscopy and oncology and haematology.
- On the critical care unit patients and relatives said they felt there was a high standard of compassion among all the nurses and doctors. They recognised the anxieties the families had and tried to reassure them all the time. One relative told us "I can't find the words to express their kindness to all of us". Cards sent to staff on the unit included the following comments:
  - "Thank you for your professionalism, compassion and humanity. I cannot praise enough the care [their relative] received from you."
  - "Thank you for the care, attention and kindness you gave to Mum."
  - "I do not have sufficient words to express my gratitude, but thank you all so much for everything you did for me."
  - "Thank you for your skill and kindness."
- Patients were given as much privacy and dignity as was practical. The layout, facilities and size of the critical care unit meant there were often limited opportunities to provide single-sex areas. Staff therefore had limited opportunities to place patients separated by gender to enhance privacy and dignity. There was one side room, and staff said they would endeavour to admit patients to this more private area when possible or practical. Patients waiting for operations in the pre-operative assessment unit, and had changed into their theatre gowns could wait in a private room. They were given the choice to sit in the waiting room to watch the television should they wish.
- Interactions with patients during nurse to nurse handovers were variable. Nurses did not always acknowledge patients or engage them in the process, despite patients being awake. However, we also observed handovers where nurses introduced themselves and explained they were completing a handover.
- During a procedure in interventional radiology, we saw how staff took the time to explain all of the procedure to a patient who was very anxious. The nurse and radiologist checked and double-checked that the patient understood exactly what was happening and this led to a calm and relaxing atmosphere.

- On Hutton ward staff members displayed understanding and a non-judgemental attitude towards patients who were living with mental health and dementia diagnoses. We saw how hard staff worked to try to ease the distress of one patient who continually called out.
- Visiting times were flexible to encourage relatives, friends and carers to visit the wards. This allowed support to be provided to patients by their loved ones and enabled friends and family to be involved in the care and treatment.
- In the oncology and haematology unit patients were invited to visit prior to their first treatment. This was completed in a small group and enabled patients to be shown around the unit. The chemotherapy programme was shown to patients through slide presentations. During treatment patients were able to bring one friend or relative with them to provide support. Patients were able to call in to the unit if they had any worries and were given an out of hours emergency number.
- 'This is me' is a document which gives details of patients likes and dislikes to help staff to provide personalised care whilst on the ward. Ward staff used this document consistently on Kewstoke ward and sometimes on the stroke unit.
- Staff spoken with said they and their colleagues provided care to patients which was respectful and considerate. They had not observed disrespectful, discriminatory or abusive behaviours or attitudes, but would be confident in raising their concerns if this was identified.

Understanding and involvement of patients and those close to them

- Patients and their relatives received regular communications and were kept informed about their care, treatment and condition. Staff made sure patients and relatives understood the assessments being done and the likely diagnosis and treatment plan by explanation and reassurance.
- On the critical care unit staff made sure patients and relatives knew whom they were and their roles on the unit. All healthcare professionals involved with the patient's care were expected to introduce themselves to patients and relatives, and explain their roles and responsibilities. Patients and visitors confirmed this was happening in practice, and all the staff they had met had told them who they were, and their role. We also witnessed staff introducing themselves in the patient interactions we observed, even if the patient was drowsy or confused.
- Staff used experienced and trained staff within the trust to provide specialist advice. Staff would also work closely with carers (including professional care workers), family and friends

to help support patients. Staff told us they encouraged family and friends to get as much involved as they wanted to be, as this was always beneficial for patients who had limited cognition.

- Staff communicated with those close to the patient and kept them informed and involved. We met families who had visited their relative on a number of occasions. They had been impressed with the information the staff had given them at all stages in the patient's stay. They had been able to ask questions and ask for advice and guidance, which had been provided. Staff on the pre-admission unit told us that when they had a patient attending who was living with dementia, mental health, autism or learning disabilities they would allow a double appointment. This was to make sure that all questions from patients and their relatives were answered, concerns alleviated and plans were put in place for a smooth admission to hospital.

Emotional support

- Staff were able to sign post patients, carers and relatives to counselling and support services. The mental health team were available to advise staff if specific information was required for mental health and drug and alcohol addiction. For patients with severe mental health concerns staff were able to refer them to the mental health liaison team based at the hospital.
- There was no psychology input for patients who had been diagnosed with a stroke or patients undergoing chemotherapy, however, services could be accessed at a local trust. When patients were notified of life changing prognoses such as cancer, the nurses referred the patient to the specialist nurse for the specialty. Stroke patients were referred to external stroke network support groups for emotional support post discharge.
- Staff handovers routinely referred to the psychological and emotional needs of patients. Staff told us patients who were suspected or experiencing depression were referred to the mental health liaison team.
- A chaplain on site could provide religious, spiritual and general support to patients. Staff told us they referred patients to the hospital chaplain. The chaplain's assistant was regularly on the ward available to offer emotional support to patients. There was a newly refurbished multi-faith chapel described as "a place for quiet reflection." All facilities were also available 24 hours a day all year round. The trust described their services as to:
  - "Offer support to all patients, visitors and staff at what can be a difficult and challenging time in people's lives."

  - "Stand alongside people, befriending, listening, offering support, showing concern and helping people reflect on their own situation."
  - "Meet people's religious needs where required through worship, prayer and sacrament."
- We witnessed an occupational therapist recommending to a patient a befriending service and explaining how this could provide friendly conversation and companionship.
- The hospital had a team of 166 volunteers who were a valuable resource to provide companionship and support to patients on the wards.
- There was support for critical care patients to be kept in touch with what was going on around them or tell them about what they might have missed when they were on the road to recovery. Critical care staff had recently introduced the use of a patient diary for longer-stay patients. Research has shown how patients sedated and ventilated in critical care suffer memory loss and often experience psychological disturbances post discharge. Diaries can provide comfort to patients and their relatives both during the stay and after the patient returns home. They not only fill the memory gap, but can also be a caring intervention to promote holistic nursing. We spoke with one family of a long-stay patient, who were starting to make entries in the diary. They recognised how this could prove supportive and practical. We were concerned that these diaries were not always going home with the patient or their relatives, and only given to the patient if they came back to collect them. These diaries should be the property of the patient at all times.

Are services at this trust responsive?

Inadequate

We rated responsive as requires improvement overall because:

- There was no sense of urgency to respond and promote discharge to initiate flow through the emergency department to the rest of the hospital to reduce crowding in the emergency department. The bed management meetings were not dynamic in ensuring flow of discharges and admissions were acted on by the wider trust and not all required staff attended.
- The emergency department was the single point of entry to the hospital for GP expected patients. There were no direct GP admission pathways in place and this further impacted on crowding in the emergency department on a regular basis.
- Lack of timely access to a specialist senior doctor to review patients overnight in the emergency department was at times leading to delays in patient admission to wards.

Summary of findings

- Patients were not able to responsively access the care they needed. There has been a decline in patients being admitted promptly once the decision to admit had been made. The trust did not consistently admit patients within 4 to 12 hours. This meant patients were in the emergency department longer, up to 20 hours and the department was much busier as a result.
- Patient flow within the hospital affected theatre utilisation and cancellation rates. The ambulatory emergency care unit and discharge lounge were underutilised and the medical assessment unit was ineffectively used.
- Surgical patients were being cared for on medical wards and as in-patients on the day case unit as a result of pressures on beds. Medical patients were being cared for on surgical wards. The trust seemed unable to rectify this position and ensure patients received care on the appropriate ward for their speciality.
- Patients were frequently and consistently not able to access services in a timely way and some patients experienced unacceptable waits for some services.
- There were difficulties with discharging patients from the hospital back into the community. This impacted on patient flow through the hospital and the emergency department. Staff reported delays were caused by transport, pharmacy and awaiting social care assessments, packages and placements.
- Discharge data showed the hospital were rarely meeting targets of 40 patient discharges per day set by commissioners.
- The hospital performed worse than the England average for length of stay in general medicine and surgery. The average length of stay for the trust was 10.1 days compared to the England average 3.6 days for medical patients and for surgery it was 3 days for elective patients, compared to 3.3 days for the England average. For surgical non-elective patients, the average length of stay was 6.3 days, compared to 5.1 days for the England average.
- Too many patients were delayed in their discharge from critical care to a ward. These delays were worse than the national average. Some patients were discharged onto wards at night as a bed had become available, when night time discharge was recognised as less than optimal for patient's wellbeing and mortality.

However:

- Some services planned ahead to meet the needs of the local population. For example, there was a plan to have 12 protected beds on a surgical ward for elective orthopaedic patients to reduce the number of cancelled operations.

- Despite the pressures and capacity issues the emergency department took account of patients' specific needs. Individual care needs and adjustments were put in place.
- Dementia was well considered across wards and units and patients were identified using a 'forget me not' magnet. There was an older people's mental health liaison nurse who provided support for patients living with dementia. The management of meals and support provided to patients during a meal time on Kewstoke ward (care of the elderly) was responsive, where patient individual needs were central.
- Staff were responsive to meeting people's needs, they were able to accommodate patient's mental health, complexities and impairments.
- On Kewstoke ward (care of the elderly) there was a 'dementia café' which provided a calm environment for patients and relatives to socialise.
- In critical care rotas were organised so most patients should be seen by a consultant within 12 hours of admission.
- The directorate leaders were responsible for ensuring learning on improvements arising from a complaint were implemented through the development of learning action plans. These were reviewed and monitored through monthly directorate governance.
- Patients told us they knew how to complain and had seen this information displayed on the ward or within information leaflets. 'You said we did boards' were displayed on wards reflecting learning and changes made from feedback, concerns or complaints.

Service planning and delivery to meet the needs of local people

- The trust at times struggled to meet the needs of the population particularity in the last year when the pressure on capacity had been high.
- The emergency department was not meeting the needs of the local population because patients waited too long in the emergency department before moving to a specialist ward. The emergency department was working to identify system wide changes to improve patient flow. However, at the time of our inspection no measureable progress was evident.
- The trust was unable to accommodate the needs of all patients over the 24 hour period. For example, children arriving by ambulance at night were transported to a local acute trust. Patients requiring critical care were sometimes cared for in recovery areas or transported to a local acute trust when capacity in the critical care unit was full.

- There was an ambulatory emergency care unit (AEC) adjacent to the emergency department. This service was set up for patients who would benefit from an urgent general medical opinion and/or treatment not available in the community, provided they were predicted to be suitable for discharge during the opening hours of the unit. However, leaders in the AEC and the emergency department were not working collaboratively to meet the needs of patients with emergency care needs.
- Some services planned ahead to meet the needs of the local population. For example, there was a plan to have 12 protected beds on a surgical ward for elective orthopaedic patients to reduce the number of cancelled operations. In medicine, the oncology and haematology department were scoping potential for expansion because local trusts were at maximum capacity and the population was expanding.
- At times of high demand, the hospital used an 'escalation' procedure. This identified that an increase in this number of in-patients would be considered if there were 15 patients or more in the emergency department corridors. For example, surgical in-patients were cared for on the day-case unit.
- Some of the facilities and premises within the hospital were not optimal for their purpose. For example, in the stroke unit, lack of space around beds compromised patient privacy and was not conducive to rehabilitation. No reality orientation clocks were visible to patients on this ward. In critical care there were no showers or toilet facilities for patients and the visitor's room did not include drinks making facilities and frequently doubled up as a consultation/meeting room. There were no facilities for these relatives to stay overnight.
- However, some areas of the hospital were well designed to meet the needs of the population they served. On Kewstoke ward (care of the elderly) there was a 'dementia café' which provided a calm environment for patients and relatives to socialise. In the emergency department there was an adequate sized waiting area, a relative's room, a separate room for children and a room for mental health assessments. The emergency department had a specified bay for patients with risks to self-harm where ligature risks had been removed.

Meeting people's individual needs

- Dementia was well considered across wards and units and patients were identified using a 'forget me not' magnet. There was an older people's mental health liaison nurse who provided support for patients living with dementia. Staff were positive about this role and felt staff and patients were well supported.

- The trust employed a complex needs sister and a strategic lead for learning disability services. Staff notified these staff when a person with a learning disability was admitted and the strategic lead would then follow up the patient either in hospital or through discharge.
- There was a learning disability working group which was about to be re-launched with representation from staff and carers.
- Situation background assessment recommendations (SBAR) were completed and sent to wards before receiving a patient. This document informed the ward of any patient needs. For example, mental health, learning disabilities or those living with dementia. On verbal handovers this was also discussed to ensure staff were aware of the patient's individual needs. A clinical alert system was also used to flag patients with a learning disability. The trust was able to demonstrate data that showed in the previous year 137 patients with a learning disability were admitted.
- The 'this is me' tool was used where possible for patients who were unable to or struggled to express their identity, such as patients living with dementia. Staff explained how these documents were very useful to help them understand patients' identity and preferences. We saw a booklet in the notes of a patient living with dementia. This booklet had been completed by a relative of the patient and explained the patient in detail, what they liked to be called what they liked to do, what was their favourite food
- In the ambulatory emergency care unit, patients living with dementia or learning disability were encouraged to bring an escort with them. Volunteers at the hospital had made 'twizzle mitts' designed to help patients living with dementia to be occupied and to feel less restless.
- Patients living with dementia were situated in the bays or side rooms that were most visible to the nursing station. Staff who provided enhanced supervision to these patients were wearing yellow tabards and were easily identifiable. Staff were allocated to a patient or a group of patients in a bay and were not to be removed unless another staff member had taken over from them.
- Since 1st August 2016, all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand and with support so they can communicate effectively with health and social care services. The trust developed a task and finish group, which met weekly to make

sure actions were being completed to achieve the standard. We saw evidence of some of the work that was undertaken, for example wards were using a visually impaired alert for the ward boards and patient bed spaces and easy to read leaflets on how to complain.

- For patients with bariatric needs equipment was available on request. Most areas of the hospital were accessible for patients with limited mobility or who used mobility aids. Disabled toilets were available for patients and visitors.
- Staff would contact the local hostel to ensure the safety for those patients who were homeless and rough sleeping, and who staff considered to be at risk due to their health on discharge.
- Patients' spiritual and religious needs were considered. Staff knew how to contact the appropriate chaplaincy lead. There was a multi faith prayer room available in the hospital.
- Patients told us when they used the call bell staff came quickly. Call bells in most cubicles were provided to patients. However, no call bells were available to patients on the corridor and in the previous eye room, now used as a patient cubicle; these patients had to shout for assistance.
- Patients with a mental health diagnosis were identified and referred to the mental health liaison team. Once patients were stable they were visited by this team to ensure their needs were being met. Staff told us how mental health patients often had key workers and it was important to ensure the key workers understanding of how they could support the patient, for example taking medication.
- We were told about how staff communicated with a patient using a white board as the patient had hearing difficulties. Staff said they listened to patients and their relatives about the best way to communicate with patients, particularly at times when patients displayed challenging behaviour.

Access and flow

- The management of access and flow from the emergency department to the rest of the hospital was inadequate. There was a lack of collective and effective focus on flow which meant patients often waited for long periods of time in the emergency department before they were admitted to a ward. When patients were admitted to a ward this was not always to the correct speciality, for example medical patients were admitted to surgical wards and vice versa.

Summary of findings

- Over the past six years, emergency department attendances had risen by 5.9%. The numbers of people attending the emergency department had continued to increase and during the period 2015 to 2017 there were sustained periods of peak demand that proved a real test to the trust.
- There was no clinical decision unit or medical assessment facility. This meant all patients being referred by their GP for either medical, surgical or oncology review were seen in the emergency department which caused an increased pressure on the department. Patients were clerked pending access to a ward, should a bed not be available, patients stayed in the emergency department.
- We saw that the minor's area of the emergency department was used as an overflow area for majors which meant minor's patients were assessed and treated in any free designated area available each day. When patients did not have access to cubicle space they were cared for on a corridor. Staff told us this practice occurred most days and was managed by the matron or nurse in charge. Staff expressed concerns that the use of the corridor was now 'the norm' instead as an action to be taken in excess situations. The corridor was staffed by nurses on a one nurse to three patient ratio and staff told us that stable patients only were located on this corridor. Should a patient's condition deteriorate the nurses would swap the patient with a more stable patient in the major's area. No incidents had been reported as a result of this arrangement; however this was a poor patient experience.
- Escalation processes in place to indicate action when the department was under pressure were not responsive. A tool was used to measure the levels of pressure within the department and prompt escalation. This dashboard was not the same measuring tool as used by the bed management meeting. The bed management team used an operational pressure escalation levels (OPEL) system which was a national tool calculation of factors to identify the status of the hospital and if escalation of actions was needed. The highest levels of OPEL escalation were levels three and four which indicated a high level of pressure in the department. Between October 2016 and January 2017 the hospital had been in level three 49 times and level four 36 times. The recording of Opel level at the weekends had been in place since January 2017.
- There was a lack of support in the emergency department by the wider hospital services and a lack of trust wide ownership around flow. Bed management meetings were not dynamic in

ensuring flow was acted on by the wider trust. There was a patient flow team but staff told us there were not enough staff in this team to successfully support the medical wards with discharge.

- The bed meetings were held five times a day Monday to Friday, at weekends there were two virtual flow meetings held daily via teleconference. Bed meetings were led by the patient flow team, the attendees required were dependent on the OPEL level. Medical matrons were required to attend four out of five bed meetings in OPEL two or above, if OPEL level one they were only required to attend at 8.30am, they were not expected to attend at 4.30pm regardless of OPEL level. Therefore, at 4.30pm medical matrons did not have direct input in to the current flow of the hospital.
- We attended bed management meetings to observe how the flow of patients through the emergency department into the wider hospital was managed. We saw on the second day of inspection the flow of patients was hampered by few ward discharges which led to patients experiencing delays in the emergency department of over 12 - 24 hours. At 9am there were already 11 patients waiting in the emergency department for a bed to become vacant in the hospital. The first bed meeting at 10.30am noted that there were nine patients in the department from the night before. There were 24 four hour breaches since midnight. By 3pm, there were 42 patients in the department, five patients in the corridor, 28 four hour breaches, 17 patients with a decision to admit but no bed available and only two patients had been discharged into the wider hospital.
- We saw that only two matrons attended the bed meeting and there were no clinicians attending. The bed management staff told us they visited each ward to tell the ward matron how many discharges were needed to reduce matron time away from the wards. This did not provide matrons with the overview of the trust and the evidence of the patients being held up in emergency department. Following the first bed meeting we did not see activity or outcome in the emergency department which had resulted from recognising escalation and wider hospital action was needed to prompt flow. The bed management team said they had to wait for beds to become available instead of proactively looking for discharges and prompting and promoting discharges be facilitated.
- There appeared to be at times disparity between information within the patient flow team and on the wards. For example, the patient flow team informed us a medical outlier in the surgical assessment unit was not going to be moved as they

were being transferred to a different hospital the following day, however, immediately after we visited this patient and the nurse in charge informed us the patient was about to move to the ward.

- The trust did not meet all national standards and clinical indicators. The continued inability to achieve these standards indicated that flow has been an on-going issue which had not been successfully addressed. The emergency department was consistently failing to meet the national standard requiring 95% of patients to be discharged, admitted or transferred within four hours of arrival. The trust did not consistently achieve the national standard for ambulance turnaround times. 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. Between January and December 2016 there was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes. In January 2016 37% of ambulance journeys had turnaround times over 30 minutes; in December 2016 the figure was 56.4%. Ambulance turnaround times over 60 minutes increased in March 2016 and remained at a level around 70 until December 2016 when they were 93. We saw that the system for informing of arrival had been developed so that reception clerked the patient and delivered the patients' paperwork to the emergency department staff. We did not observe any delays in the handover of patients to the department.
- There has been a decline in patients being admitted promptly once the decision to admit had been made. The trust did not consistently admit patients within 4 to 12 hours. The trust's performance showed an overall decline in performance from 0.6% in December 2015 to 3.6% in November 2016, the worst performance was 6.8% in September 2016. Between December 2015 and November 2016, 50 patients waited more than 12 hours from the decision to admit until being admitted. The highest number of patients waiting over 12 hours was in November 2016 when there were 34. The trust has reported 54 trolley breaches since 20 December 2016.
- Patients spent longer in the emergency department compared to the England average. Between November 2015 and October 2016 the trust's monthly median total time in A&E for admitted patients was consistently higher than the England average. Performance against this metric showed an overall decline from 170 minutes in November 2015 to 192 minutes in October 2016.
- Access to a specialist senior doctor to review patients overnight in the emergency department was limited and delayed patient

admission and so reduced flow through the department. The medicine team had one registrar and senior house officer (SHO) on duty overnight to cover the medicine wards and the emergency department, so if called they would need to prioritise the urgency. We saw the night medical team responding to a medical emergency and provided support for the emergency department. While patients might be seen overnight by the specialist registrar or senior house officer, the patient would still have to wait in the emergency department until the following morning to be seen by the speciality consultant for a definitive decision about admission.

- There had been a recent increase in patients leaving the department without being seen. Between November 2015 and October 2016 the trust's monthly median percentage of patients leaving the urgent and emergency care services before being seen for treatment was overall similar to the England average. There was a period between May 2016 and July 2016 when the performance was better than the England average and in the latest month available (October 2016) the trust percentage was 3.4% compared to the England average of 3.0%.
- The medical assessment unit was not being used effectively. An effective medical assessment unit will be used for further tests, stabilisation and assessment before patients are discharged or transferred to the relevant ward. All patients came from the emergency department, however, the medical assessment unit was regularly at full capacity which limited their ability to take patients from the department. On a medical assessment unit a patients length of stay should be limited to less than 48 hours. The hospital's medical assessment unit was typically an inpatient ward and patient stay was in some cases exceeding 48 hours. The data for the medical assessment unit reported an average length of stay of 2.1 days between March 2016 and February 2017. Management acknowledged pathways between ambulatory emergency care and the emergency department required further embedding.
- Data provided evidenced the underutilisation of the ambulatory emergency care unit to pull patients from the emergency department. For November 2016 patients were pulled 113 times which was an average of 3.7 patients a day. In December 2016 125 patients with an average of four patients per day. In January 2017 there were 113 patients, 3.6 patients per day and in February 2017 there were 95 patients, 3.3 patients per day. Patients were considered suitable for the ambulatory emergency care unit if they required urgent assessment or treatment, or would benefit from an urgent

general medical opinion not available in the community. During the three months prior to our inspection, 55% of referrals came from the wards within 72 hours of discharge, 32% of referrals to the unit came from the emergency department and 11% of referrals came from GPs. Referrals were also accepted from the ultrasound department. One month prior to our inspection, the ambulatory emergency care unit had introduced a system whereby ambulance staff could phone during transit of the patient in order to speak to the doctor and determine whether the patient could be brought straight to the unit and bypass the emergency department. At the time of our inspection this new protocol had not yet been evaluated. On the day of our inspection, three patients had been brought directly to the unit following this process.

- There were difficulties with discharging patients from the hospital back into the community. This impacted on patient flow through the hospital and the emergency department. This problem with discharge included both home and discharges to community residential accommodation. This had a cumulative impact in the department and contributed further to crowding. Staff reported delays were caused by transport, pharmacy and awaiting social care assessments, packages and placements. During our inspection 14 out of 24 patients on Kewstoke ward (care of the elderly) were medically fit for discharge and awaiting packages or placement.
- Discharge data showed the hospital were rarely meeting targets of 40 patient discharges per day set by commissioners. Between 1 November 2016 and 23 February 2017 there were 115 days, of which only 27 (23.5%) of days achieved the target of 40 patient discharges. For the same time period only 46% of days achieved the target for 20% of patient being discharged before 12pm.
- On 01 April 2017, the hospital had made in total one discharge before 8.30am, two discharges at 12.30am and 19 discharges at 4.30pm. This indicated patients were not regularly discharged before 12.30pm and, therefore, there was not the early identification of available bed space on inpatient wards.
- On the whole we saw expected dates of discharges for patients were planned on admission to the ward, any change to the expected date and rationale was included within medical notes. We observed nursing handovers to discuss queries with discharges and reasons for delays. On the rehabilitation ward, a new staffing model was being trialled. This included a band three ward coordinator whose role was to complete many of

the administrative tasks required for patient discharge. The ward team anticipated this new role would ensure a more smooth discharge process as well as freeing up time for qualified nurses to spend with patients.

- The trust monitored their 'green to go' patients, which was the total number of patients who were ready for discharge who had yet to be discharged, the goal was for 30 patients daily to remain in the hospital. Reviewing weekly data for a six month period between August 2016 and January 2017 the trust were consistently above the 30 'green to go' target, data ranged between 28 and 65 patients, with a median of 44.
- The trust also monitored delayed transfers of care, these were patients from the 'green to go' list who were ready to go home or move to a care provider but were unable to be discharged due to a variety of reasons. Data reflected delayed transfers of care which were attributable to both the NHS and social care. For example, in November 2016 13 patients had delays attributable to the NHS which included waiting for a nursing home, community equipment/adaptations and patient or family choice. There were 15 patients with delays attributable to social care to include completion of assessment, residential home, nursing home and care packages in their own homes. We observed a call between the integrated discharge team and social workers, which took place daily. This was a well-structured call and used the 'green to go' list to discuss each patient. The discharge case managers were clear on expectations from social workers and the next steps which required completing. The discharge team were knowledgeable about all patients on the 'green to go' list and pushed to move processes forward.
- Patients exceeding seven days length of stay were discussed weekly between matrons and commissioners and chaired by the head of patient flow. These meetings were not minuted. We were told the names of patients who were identified as medically fit for discharge would be added to the 'green to go list' in the same afternoon.
- There were regularly a high number of outliers within medical care, a clinical decision was made on the suitability of outlying patients. Data for outliers showed between September and December 2016 there were 1,032 outliers in surgical directorate beds. At the time of our inspection there were a low number of medical outliers, however, two surgical wards were shut due to an outbreak of contagious infection. We visited three outliers and confirmed they were reviewed daily by medical staff. Outliers would be visited following ward rounds, however, if there was a potential discharge it would be requested for the

outlier to be visited by medical staff before the ward round. During our inspection, we were assured of the safety of surgical patients outlying on medical wards. Cheddar ward had surgical patients who were being reviewed daily by the critical care outreach team, not due to their acuity but to offer support and guidance to staff.

- The average length of stay for medical elective patients (for example planned admissions on the rehabilitation ward) between October 2015 and September 2016 was 6.3 days, this was higher than the England average of 4.1 days. For non-elective patients the average length of stay was 6.3 days, which was lower than the England average of 6.7 days. In particular for general medicine the average length of stay for the trust was 10.1 days compared to the England average 3.6 days. The trust reported in February 2017 data where average length of stay was 3.3 days for finished consultant episode and 5.2 days for patient episodes under the care of one consultant.
- The discharge lounge was underutilised and, therefore, patients remained on wards. Staff told us there were approximately six patients per day. The discharge lounge was open from 9am until 6pm Monday to Friday. Hours could be extended 8am to 8pm particularly on Monday and Fridays with winter pressures. Data for a six month period showed 887 patients from 8,724 discharges used the discharge lounge, this was a 10.16% utilisation.
- Surgical services were under pressure due to increased medical patient admissions to the hospital; this led to surgical beds being occupied by medical patients. The result of this meant that sometimes surgery for some patients had to be cancelled.
- Bed occupancy was recorded monthly and showed that the trust were red on their RAG (red, amber, green) status and during October and November 2016 the trust exceeded their capacity. In-patients being cared for on the day case ward and on medical wards reflected this in surgery and from October 2016 to December 2016 there were in total 830 outliers of medical patients in surgical beds. During this period, 118 operations were cancelled, 49% of these were due to a lack of inpatient beds. The hospital worked hard to try to reduce the numbers of operations cancelled and had inpatients cared for on the day case unit and during quarter three, 39 patients were cared for on medical wards. The hospital tried to cancel theatres the day before the list was scheduled to run and this included phoning patients on a Sunday if they were due for admission on a Monday. Quarter three (2015 to 2016) to quarter

two (2016 to 2017) showed that the hospital cancelled 149 operations. Out of these 149 cancellations, only 6.7% were not treated within 28 days. With the exception of quarter one (2016 to 2017) these results were lower than the England average.

- Between December 2015 and November 2016 the hospital's referral to treatment time (RTT) for admitted pathways for surgical services had been about the same as the England overall performance. The latest figures for November 2016, showed 69.7% of this group of patients were treated within 18 weeks compared to the England average of 71.4%.
- Between September 2015 and August 2016 the average length of stay for surgical elective patients at the hospital was 3 days, compared to 3.3 days for the England average. For surgical non-elective patients, the average length of stay was 6.3 days, compared to 5.1 days for the England average. The top three elective specialties showed trauma and orthopaedics average length of stay was 4.1 days compared to an England average of 3.4 days. Urology and general surgery were both below their respective England averages.
- The surgical directorate performance management review in October 2016 identified areas of underperformance as not all patients were admitted to an orthopaedic ward and operated on in a timely manner. The National Institute of Health and Care Excellence recommended that patients with fractured neck of femurs should be operated on within 48 hours of admission. The proportion of patients having surgery on the day of or day after admission from July to November 2016 averaged at 83% which was just below the national standard of 85%. Increased mortality rates for this group of patients had been identified and was included in the hospitals mortality reduction plans.
- Theatre utilisation had been significantly less than the hospital target of 85% and scheduling meetings were implemented. The meetings aimed to look ahead six, three and one week to identify actions such as confirmation of theatre sessions, booking and confirmation of consultants and anaesthetists and the final lock down of the theatre list one week ahead before it went live. Once this list was locked down, only certain senior staff could alter it, when this happened the list changed colour to show that it had been updated. This ensured that all departments had the same colour and, therefore, the most up-to-date version. This worked well and could be seen in a slight improvement in theatre utilisation, however, the target of 85% was not yet consistently achieved
- Since our last inspection a theatre scheduling group had been established to review weekly theatre utilisation alongside a scheduling policy. The aim was to increase theatre utilisation to

85% across day case and main theatres. Utilisation across all of theatres for quarter three (2016 to 2017) was 77.3%, 73.6% and 81.5%. Staff told us this was for a number of reasons but mainly due to cancelled operations.

- There were an unacceptable number of patient discharges from critical care being delayed due to a bed on a ward in the hospital not being available. Similar to many critical care units in England, data from the Intensive Care National Audit and Research Centre (ICNARC) reported a high level of delayed discharges from critical care. In the years from 2012/13 to 2015/16, delays in discharges by more than eight hours had been around 10% on average. This was against a national average of around 5%. The rate had dropped to 9% in 2015/16. However, in the first six months of 2016/17, the rate had accelerated to affect 19% of patients. This was also against a national average of 5%. In raw data for December 2016, 25 of 28 patients were delayed by more than four hours. Evidence showed one patient had been delayed within critical care for nine days, in a unit with no toilets and showers, so requiring the patient to use one of the adjacent wards.
- The discharge of patients from critical care was not always achieved at the right time for the patient. The unit was above (worse than) national averages for moving patients at night. Studies have shown discharge at night can increase the risk of mortality; disorientate and cause stress to patients; and be detrimental to the handover of the patient. Data from ICNARC for discharges made out-of-hours (between 10pm and 7am) showed the unit above the national average for night time discharges for similar units for the last five years going back from 2015/16. It appeared the rate was beginning to fall, and the 12 patients in the 2015/16 year had fallen to four in the six months from April to September 2016 (the most recent data from ICNARC). However, data from the trust for the month of February 2017 showed there were a further six patients discharged at night.
- The critical care unit had higher occupancy levels compared with recommended levels and national averages. The high occupancy levels were due to a lack of a ward bed into which to move a discharged patient, and, as with the national picture, an increasing demand for critical care beds. Detailed occupancy figures for critical care for July to December 2016 (taken on the fourth Thursday of each month at midnight) showed the rate had been 100% in five of the six months. In the other month, it had been 80%. The average of this occupancy was 97% against an NHS average for the same six-month period of 82%.

Learning from complaints and concerns

Summary of findings

- There was a complaints operation policy within the trust. It outlined the actions to be taken and offered guidance on good practice at each stage of the process. The policy took into account the Patients Association – Good Practice Standards for NHS Complaints Handling It was scheduled for review in November 2017.
- All staff were aware of their responsibility to listen and respond to concerns and complaints raised by patients, their relatives or carers.
- Complaints were received and processed by the patient advice and complaints team in the first instance who carried out an initial risk assessment. Telephone contact was made within 48 hours and a formal acknowledgement was sent within three working days of receipt. At the time of acknowledgement the trust offered to discuss with the complainant the manner in which they would like their complaint to be handled and the response period for the investigation and final response.
- A complaints investigator was appointed to carry out an appropriate investigation. They established the underlying cause of complaints through root cause analysis and linked their investigation to any safety incidents. If there was a risk of harm to a patient or member of staff or a potential safeguarding concern then an incident was raised on the electronic reporting system and investigated appropriately.
- A written response was provided or a meeting offered following an investigation. The response was signed by the person investigating the complaint. The Chief Executive wrote an accompanying letter and both were sent to the complainant within the timescale.The final response included an offer to meet should the complainant remained dissatisfied and also explained how to contact the Parliamentary Health Service Ombudsman (PHSO). Responses were expected to be made within 40 days of receipt. Complainants were advised of any anticipated delays and provided with a revised date of response
- The relevant directorate general manager, clinical director and assistant director of nursing were responsible for ensuring learning and improvements arising from a complaint were implemented through the development of learning action plans. These were reviewed and monitored through monthly directorate governance.
- Complaints featured in the trust's induction and mandatory training. Training was available on basic investigation skills and root cause analysis for staff involved in the investigation of

complaints and draft responses. The complaints manager was also available to work with individuals to address specific training needs and had devised a training programme to support investigators and to improve the quality of responses.

- Between April 2014 and March 2015, 1397 contacts were made with the patient advice and complaints team (23 of which went on to be registered as formal complaints) and 238 formal complaints were registered. This was a 5.7% increase on the previous year. Only 74% of complaints were resolved within the timescale which was individually agreed with the complainant and 31% of complaints were upheld.
- The governance systems were clear and in place. There was a clear audit trail for monitoring and progress of complaints. The complaints manager provided monthly and annual reports to the board and provided regular statistics at trust and directorate level. Data included volume, response rates, categories, learning and improvements identified and the number of PHSO reviews requested.
- During the 2014-15 year an internal audit of the trust complaints handling process was undertaken, the report of which was made available in February 2015. Recommendations included: notifying complainants of possible delays as soon as possible; improving the number of complaints responded to within timescales; and improving the documentation of the dates complaints were received.
- We saw the latest monthly report for January 2017 where overall performance was compared against previous months and was further divided into performance for emergency performance, surgery performance and clinical support performance. Themes were categorised into attitude, care, communication, diagnosis, information and waiting times
- Our review of four complaint files showed that complaints were responded to in a timely manner. The investigations were thorough and responses were open, apologetic and provided adequate information to the complainant. Responses to the complainants concerns were signed by the investigator or complaints manager and were accompanied by a letter from the Chief Executive. Responses demonstrated empathy, compassion and personal sincerity. There was information about learning within the files demonstrating new processes had embedded.
- All complainants were given details about how to contact an independent advocacy service for additional support.

Summary of findings

- The complaint files we reviewed related to, delays in treatment, unsafe discharges, administration delays and cancelled appointments. One complaint was upheld and the other three were partially upheld. All responses were sent within the 40 day target.
- A complaint satisfaction survey was sent to each complaint within one month after the final response and included feedback about the confidence to speak up; how easy it was to make a complaint; if they felt listened to and understood; did the complaint make a difference and how confident they felt in making a complaint in the future. The survey results were reported in the complaints report and presented to the Patient Experience Review Group

Are services at this trust well-led?

Requires improvement

We rated well-led as requires improvement because:

- Despite a strategic vision there was a lack of assurance for delivery of the vision as the trust remained reliant on external solutions.
- The lack of progress in securing clinical leadership and a substantive medical workforce in the emergency department had not enabled improvements to the service to meet the needs of patients.
- Some progress had been made since the governance review although there was recognition that further strengthening of directorate governance and board to ward assurance was required.
- The trust was not meeting their contractual obligations under the Workforce Race Equality Standard.
- The on-going changes in executive leadership at a time of continued pressure and uncertainty posed a risk of further instability.
- Lack of progress in reducing hospital mortality was frustrating with overarching action plans not reflecting the commitment to mortality review and sharing of learning at all specialities.

However:

- The recent partnership working was seen as positive and some early progress for support had been put in place in the emergency department.
- The director of nursing was seen as approachable and providing support to drive nursing in the trust.
- Patient and staff stories at the board enabled members a better understanding of the challenges faced by staff and where improvements could be made for patient experience.

Summary of findings

Leadership of the trust

- Senior leaders at the trust including the chief executive, medical director and director of nursing had been in post permanently for between a year and 18 months. The director of operations was an interim post for the previous six months. Further changes were about to occur with the current medical director and interim director of operations leaving in April 2017. Both of these positions were about to be replaced with permanent appointments which was pleasing to see but would inevitably lead to further periods of change and focus.
- The chief executive was described by the board members as open and listening to challenge with the executive team working well together in a supportive and mutually challenging relationship.
- Some of the executives spoke of working closely together which was particularly evident in relation to the emergency department. The medical director, director of nursing and interim director of operations spent a significant amount of time and focus there especially at times of escalation, to provide support to the department in the absence of a clinical lead. The challenge of recruitment was on-going and despite sustained efforts to recruit clinical leadership, this was unsuccessful.
- Oversight of the issues and demands on the emergency department were good, however, a reliance on these executives had the potential to create a dependency and expectation. The high level of input could draw them away from the other elements of their role.
- Due to the small size of the trust capacity and capability of the executive team and other leaders was a concern. Some key leaders referred to the stress that they were under expressing this as 'wearing many hats' a phrase we heard many times which meant that key leaders were under considerable pressure. Staff reflected the response to this pressure as being at times, reactive rather than proactive.
- Non-executive directors played key roles in chairing some trust committees. Some had been in post for a number of years. Others although new to the trust, had a range of health and social care experience and previous non executive role experience. Areas of risk were well documented within the organisation with at times little progress or robust review, for example many risk register entries were several years old and remained unresolved. This raised a question about the

effectiveness and consistency of the oversight and challenge provided by the non-executive directors. It was difficult to find evidence of impact and influence in terms of driving improvements and change.

- The lack of clinical leadership in medicine and the emergency department also had a significant impact in terms of oversight and strategy. There was evidence of frustration at a lack of strategic planning amongst senior clinicians which impacted on recruitment and retention.
- There was a mixed picture on the visibility of the chief executive, some staff told us of 'Ask James' sessions where any staff could meet the CEO, others said he took time to speak with them but others felt visibility was low.
- Nursing and medical staff across the trust spoke highly of the director of nursing describing her as approachable and visible with 'an open door' approach. It was evident that she had been the driver for several changes including 'ward Wednesdays' when the matrons and ward managers met to discuss quality and nursing issues and share learning.
- Matrons were said to be busy and often did not have time to focus on leadership and directorate managers were at times less visible due to the increases on bed pressures when the hospital was in escalation.
- The lack of clinical directors and divisional leadership in the medical and urgent care services had an impact with staff feeling there was a lack of decision making and with the high number of changes at executive level this led to even more changes.

Vision and strategy

- The lack of a long term vision for the trust was creating uncertainty and this was affecting the ability to deliver good care on a day to day basis.
- The strategic vision was articulated as: delivering harm free care and efficiency, transforming partnership working and new models of care and sustaining the trust within the Sustainability and Transformation Plans (STP) and the health and care economy. However, there was a lack of strategic grip internally and externally with development of the future for the trust being too dependent on external solutions. The trust was not taking enough action to achieve this certainty which was demonstrated in lack of progress and pace in resolving the problems in the emergency department. The system solutions in place to address this at the time of the inspection were yet to have a lasting impact. We saw the vision was displayed on staff notice boards and staff across the trust were aware of the

vision. However, within the emergency department staff were aware of the vision of the trust but not of the strategy for the emergency department or the strategic development of the service.
- Shortly prior to our inspection the chief executive had made an announcement to staff that the boards of Weston Area Health NHS Trust and University Hospitals Bristol NHS Foundation Trust had agreed to establish a formal partnership arrangement, increasing the level of joint working between the two trusts.

"This new collaboration is being created as part of the NHS vision of developing networks between smaller and larger Trusts and reflects the on-going North Somerset Sustainability programme to build a strong future for Weston General Hospital. Building on long-standing, positive working relationships which give local people access to a range of services delivered or supported by Bristol and Weston clinicians."

- The two trust boards had met once prior to our inspection and executives were positive about the agreement and were looking forward to developing the partnership further.
- The trust had a set of values known as PRIDE – People and partnerships, reputation, innovation, dignity and excellence and equality. We saw some evidence of the values but these did not seem to be well embedded. We did not see the values consistently displayed.The trust had defined behaviours which support PRIDEand recognised they needed to be embedded and had a plan to do this.

Governance, risk management and quality measurement

- A review of the trust governance structure had been undertaken since our last inspection in early 2016 making 12 recommendations. Although actions were in progress the executive team described the governance arrangements as immature recognising more work was needed to strengthen this at speciality and directorate level. The new structure proposed each directorate reporting to either the director of nursing, the medical director or director of operations to strengthen accountability. An associate medical director was due to start in post in April 2017 with responsibility for both the medical and surgical directorate and was seen as key to strengthening the revised structure alongside an assistant director of nursing and quality and governance facilitators. With consistent reporting structures and monitoring processes there was confidence that quality improvement and clinical audit would become embedded. Although not evident yet at the time

of the inspection we were not assured it was well embedded across the trust. For example, an Emergency Directorate Governance Meeting was held every two months. Standard items on the agenda included risk and incident management, national guidelines and trust policies, patient experience, clinical audit, infection control, safeguarding, staffing and staff management, education and training and quality and governance reports. We reviewed minutes for July, September and November 2016 and identified instances where reports and meeting minutes were not received by the Governance Committee and which would lead to gaps in assurance and a lack of information being fed up the governance structure to the Trust Board.

- Another key position of trust secretary had come about from the governance review. The role was said to bring improved focus on the quality of board papers which currently did not reflect or demonstrate non executive challenge at these meetings, despite the non executives we spoke with telling us they often held the executives to account. Recruitment to the post was active at the time of our inspection.
- As part of the process to ensure robustness around serious incident investigation and to address the backlog, monthly serious incident panels were in place led by the director of nursing with input from the CCG and representation from the patient council. We reviewed a number of minutes which demonstrated new incidents were discussed and action plans from incidents reviewed for evidence that actions had been taken as intended with a view to findings influencing the audit programme.
- The focus on quality in the trust was said to be improving over the last three years although further maturity in the scope and scale to improve oversight, was recognised. The Quality and Governance Committee met monthly and was chaired by a Non-executive director lead for quality. Terms of reference reviewed in October 2016 set out reporting and accountability. Key focus areas for the committee included mortality and morbidity and although case note reviews were undertaken we felt the committee could provide a greater degree of challenge for assurance the detail was identified. Since the governance review less sub committees were reporting to the Quality and Governance Committee which was seen as a positive step, as previously the high number of reports had led to insufficient time to cover all effectively. The Clinical Advisory Group was set to be more proactive and driving safety with multidisciplinary representation.

Summary of findings

- An electronic governance system facilitated the reporting and management of incidents. It has been extended to include the complaints and risk register module to provide comprehensive reporting to support greater triangulation of risk. Each weekday all incidents were risk scored by the governance team. Integration with other assurance reporting streams (for example concerns raised via the Patient Advice and Liaison Services and agency staff usage), took place and executive and operational leads were updated through the Senior Management Group meeting regarding any apparent trends. The head of governance and team co-ordinated serious incidents requiring investigation, and adverse incidents, which were reported and managed through the Directorate Governance Committees, Quality and Governance Committee and by the Trust Board.
- The corporate risk register contained well established risks some having been recorded for a number of years which were felt to 'be stuck' and difficult to resolve. The top risks were management of patient flow, ability to recruit medical staff in the emergency department and other areas of the trust and timeliness of medical review in the emergency department. The focus appeared to be on the effective capture and recording of risks rather than the management of them. Some controls recorded as being in place were not effective in practice such as for timeliness of medical review in the emergency department. While these risks were recorded and reviewed there had been no change to the level of risk or action taken to ensure they were fully mitigated and the level of risk reduced to improve patient safety. Others identified gaps which were critical to reducing risk such as a lack of training programme for pressure ulcers. Top risks on the board assurance framework had some parity with the risk register and included mortality as a high risk recognising that the limited mortality reviews in specialties and lack of embedding learning into practice were key gaps in assurance.
- We were assured the Board were kept informed of the on-going risks in the emergency department over the Christmas period when staffing the department was critical and could have led to a divert of patients. The non executives also attended a debrief in early January. While the continuous and substantial focus on the issues in the emergency department provided detail for assurance there was a danger that the NEDs could be drawn into operational aspects.
- Following the increase in demand and safety concerns in the emergency department, assurance of emergency department safety was provided at a further monthly Clinical Oversight Group meeting, by way of a quality and safety dashboard and

verbal feedback in relation to any patient safety events. The Clinical Oversight Group was set up following the conclusion of a previous risk summit process to provide monitoring of improvements. Chaired by NHS Improvement, its remit is to oversee and assure the delivery of safe urgent and emergency care service. It is an oversight group. Despite the remit of this group the emergency department clinical lead for medical and nursing was not included or represented on this group. The department was represented by the medical director in the absence of a clinical lead.

- The Emergency Department Task and Finish Group was created by the trust in response to specific circumstances regarding clinical and financial sustainability at the trust. The group had been set up with three specific objectives; they included Operation Seagull, innovative recruitment models and alternative overnight staffing models for the emergency department. This was a task group and fed back to the wider system sustainability board who remained the key local oversight group.
- It was unclear whether there was a robust clinical audit programme in place. Many staff told us about the 'Hub' which appeared to lead a lot of quality improvement work mainly in conjunction with medical staff. We were told the 'hub' and the relevant speciality had visibility of action plans from audits. This was not shared more widely, for example ward sisters were not aware of actions and audits were not always shared with the directorate governance team.
- Mortality rates were not reducing in line with England targets and this was identified on the board assurance framework. This risk was reflected in the quality of some of the Mortality and Morbidity meetings where there was at times a lack of regular attendance by some medical staff, lack of documentation for updating action plans and sharing learning in a number of specialities. The medical director was the lead for mortality driving the mortality review process and trust wide action plan. A recent report in February 2017 identified progress with the 7 quality improvement projects linked to mortality reduction with fractured neck of femur and management of emergency referrals rating red. Despite the activity there was little sustained progress with the most recent data issued in March 2017 continuing to show the trust as worse than expected for mortality. The latest data showed actual deaths of 1,007 against an expected number of 875. There had also been little improvement between this data set and the previous one, which covered July 2015 to June 2016 (released in December 2016).

- The safeguarding lead reviews all datix incidents submitted to identify those with a safeguarding element to them. All serious safeguarding issues are overseen by the Safeguarding Lead. However, there were concerns at the length of time it took for investigations to be completed. These were assigned by the governance team mainly to ward sisters who it was said had limited time due to other workload commitments. There were quarterly safeguarding meetings and an annual report to the board with the director of nursing being the executive lead. A safeguarding risk register was reviewed at the quarterly meetings.
- The integrated performance report was immature and simplistic and was not in line with recognised NHS best practice. Although information on people, performance and financial matters was contained in a single report the reports themselves did not consistently address the key strategic issues and risk. This meant that the board did not have the best possible analysis available to them to inform discussion and decisions.
- There was a plan to introduce a workforce committee to the governance structure. This was about to begin with a first meeting being planned in March 2017. Previously work streams in this area had been via the Quality and Governance Committee with a limited focus on training and staffing. Recognition of the need to implement a robust organisational development programme had begun which would aim to provide leadership which was supportive and also hold people to account. The findings of an external review were presented to the board in January 2017 and would be triangulated with the latest staff survey results to inform the strategy.

Culture within the trust

- A series of strategic solutions had been developed for Weston hospital over the years and many had fallen at the last moment. These had an impact on staff morale and there was evidence that the last failed acquisition remained a live and unhappy memory for many staff. Many staff that we spoke to were very keen to have the future settled and it was felt that certainty about the future would improve the chances of recruiting and retaining staff.
- The on-going challenges in the emergency department were said to have overshadowed everything with meetings often being cancelled causing concern that other services and developments were at times on hold.
- Despite the pressures staff told us they enjoyed working in the emergency department. They felt respected and valued

amongst their peers but did not feel valued, listen to or supported by the hospital leadership. The general feeling of the staff was that they felt isolated and unsupported and despite efforts made their situation had not changed. The culture of the wider hospital to support the emergency department was not considered by staff to be proactive. There was poor cooperation between levels and conflict between medical teams on the wards.

- There appeared to be a lack of collaborative working and a poor relationship between some services and departments. Talking to staff in both the emergency department and on the ambulatory care ward, there appeared to be limited proactive steps taken to identify and 'pull' patients from the emergency department and, therefore, the ambulatory emergency care unit was being underutilised. Interface meetings with the two teams had stopped approximately 12 months prior to our inspection. This meant recent challenges of demand and capacity were not being successfully addressed using a collaborative approach at the hospital 'front door'. We were also told communication between critical care and medical consultants was poor, especially regarding transfer. This posed a risk of information not being shared appropriately and decisions not being made quickly to ensure the safe transfer of patients.
- Staff in the theatre departments spoke of how strong leadership had made changes to the safety and the culture of theatres. Staff told us how well the safety standards had been set up and worked effectively even in the absence of the senior management team.
- Culture for reporting of incidents was positive and many staff spoke about the hazard line and gave examples of using this to report concerns.
- A linked initiative to the hazard line was the 'heart line' which staff use to provide positive feedback about the actions and support they had received from other staff. The full transcript of the feedback along with staff names was included in the bulletin so individuals could be recognised for their actions.
- There was a recurrent theme of bullying and people fearing to speak up and this was substantiated by the staff survey results. The percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months was 31%, (mainly the same as 2015) and remained much worse than the national score of 25%. The trust had a Freedom to Speak Up Guardian which was said to be going well, being publicised around the

hospital and through a session on trust induction. This was seen as evidence of the trust attempting to make it easier for staff to report issues and raise concerns. Themes emerging were reported to the board.

- Staff wellbeing was a positive aspect of working at the hospital with yoga sessions and a gym where an 'honesty box' was the method of payment which was to encourage more to use the facility.
- Junior doctors spoke of a lack of support; at times study leave and annual leave were not approved. They also felt the pressure of senior staff being 'spread thinly' leading to lack of supervision with juniors being the most senior person on a ward.
- Being a small trust was seen as a positive as people got to know each other well building relationships and being able to ask for advice and support. Many told us they were proud to work at the hospital and many were loyal to be working for the community they lived in. The staff we spoke to felt that there was a lot to be proud of and their dedication to their patients and colleagues was obvious to the inspection team.
- The challenges of resolving the medical staff recruitment difficulties were recognised as in part due to being a small and non specialist hospital. However, a negative attitude displayed by some medical staff was also cited as not being supportive in attracting new employees. Priorities for the future were to have more permanent senior medical staff and medical leadership and a stable executive team which was hoped would improve culture.
- The 2016 NHS staff survey was published during the time of our inspection. 572 staff took part in the survey with some results staying the same and others either marginally better than 2015 or worse. Key results were:
  - I would recommend my organisation as a place to work in was worse than the England average of 62% in 2015 (54%) and in 2016 had deteriorated further to 52%.
  - Staff recommendation of the organisation as a place to work or receive treatment demonstrated no change from 2015 at 3.58 which was in the worse 20% of England average which was 3.77.
  - Percentage of staff reporting errors, near misses or incidents witnessed in the last month for the trust was 91% (same as 2015) against a national of 90%
  - Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month was 42% (2015 – 37%) which was worse than national score of 31%

  - Percentage of staff reporting good communication between senior management and staff same as 2015 at 25% but this was lower than national score of 33%
  - Percentage of staff agreeing that their role makes a difference to patients/ service users had deteriorated since 2015 (90 %) to 88% which was worse than the national score of 91%
- Disappointment was expressed by executive leaders at the lack of progress in the staff survey results with a plan for a renewed focus on the current action plan to understand why little improvement had been made. The inspection team noted that a transactional approach had been taken in responding to the staff survey results with an action plan that had not, at the time of the inspection, been delivered. The team considered that a different approach, addressing culture and staff engagement, might have had a different outcome.

Equalities and Diversity – including Workforce Race Equality Standard

- There was limited evidence that equality and diversity was a priority at the trust in their capacity as an employer although there was no evidence of any failure to meet their legal and regulatory obligations in line with the Equalities Act 2010. There was strong evidence that the trust took a deliberately inclusive approach in their provision of care with a focus on people living in vulnerable circumstances. This was evident on the wards and in aspects of their work with partners.
- The trust was not meeting their contractual obligations under the Workforce Race Equality Standard. The board had not received an annual report as required and there appeared little awareness of the requirements. In the discussions about this the trust referred to this as a failure of governance. The 2015 staff survey results showed a significantly worse position for black and minority ethnic staff who were more likely to experience violence and aggression from both patients and staff, more likely to experience bullying and harassment and less likely to be shortlisted for vacancies. The trust did not have a network for black and minority ethnic staff. At the time of the inspection the Equality and Diversity Committee was moribund although we were told this might change once the newly formed People Sub-Committee got underway.

Fit and Proper Persons

- The team reviewed the trust's policy and arrangements for meeting this regulation and examined a sample of personnel

files for executive and non-executive directors (NEDs). The trust's recruitment policy contained reference to the need to ensure that the people appointed were fit and proper. Although there was no evidence of a document detailing the processes to be followed there was a comprehensive checklist within the files examined, all of which had been completed and key actions had been dated and initialled. There was evidence on the file of the checks undertaken which included identity checks, confirmation of eligibility for appointment, insolvency and bankruptcy checks and checks for a criminal record through the disclosure and barring service. Relevant documents were retained appropriately on all the files examined. This amounted to a rigorous and thorough check at the appointment stage. For non-executive directors there was an annual declaration of on-going fitness as part of the appraisal process and we saw that these had been completed. There was no evidence of a similar annual declaration process for executive directors.

Public engagement

- In February 2017 the North Somerset CCG announced a period of public engagement around the future of services at the trust. This was welcomed as the public had not previously been able to contribute their views on the future of the hospital.
- Excellent engagement through the Patients' Council (in the absence of Governors). Members had meaningful involvement at board and subcommittee level and attended the serious incident review panel. There was agreement that this added value.
- There had been excellent engagement with the police and the relationship with them had been transformed to their mutual benefit.
- Patient stories at the trust board presented by staff gave an opportunity for learning and hearing of patients experiences of care and treatment.
- On entrance to wards 'you said we did' information was displayed. For example, you said ' better mattress' we did 'new bed and mattress in trust'. The wards also provided information on who the public should speak to if they wanted to comment, raise a concern or complain.
- There was good engagement with the Sustainability and Transformation Plan for the area.
- As part of the strategy to improve public health schools were taking part in a project where they could use an area of green space on the hospital site to grow vegetables.

Staff engagement

Summary of findings

- In the time since our previous inspection uncertainty around the future of the hospital remained which was seen to have left a scar with low staff morale. However, in February 2017 there were the two announcements about the future of the trust. We heard mixed views from staff about the plans to work more closely in partnership with University Hospital NHS Trusts in Bristol and the North Somerset CCG announcing a period of public engagement around the future of services at the trust. Some staff were not concerned about the proposals and others worried what this would mean for the emergency department. A plan of staff engagement around the CCG proposals were being led by the leadership team with ward based sessions being seen as an important way for staff to access information and ask questions.
- Staff in the emergency department told us their views were not considered and they did not feel involved in how decisions about their department were made and were not aware of any specific role they had in developing the department's future. Consultation was taking place about the future of the department; staff did not feel included in the discussions
- Staff success was celebrated through the 'celebration of success annual awards', staff spoken with were proud of awards received either individually or as a team.
- There was an active trade union group representing staff on the JNCC which was said to be improving with a work plan and agenda which enabled staff feedback and experience to be heard. Although this could be improved to allow time for conversations with the attending executive. The staff survey in 2015 top and bottom five scoring areas had been discussed and the action plan shared with the committee. Members recognised issues with ward clerks which had been raised with the CQC team. This was a result of an administration review in 2011 where reductions in posts and hours of these staff had come about which did not always meet the needs of wards. Concerns around communication and staff engagement through the plans around the emergency department and the external consultation, were a theme along with a lack of clarity in leadership at many levels in the organisation and people wearing many hats. The group, however, recognised a lot of good work at the trust but felt this should and could be better acknowledged.
- Whilst the future of the emergency department was under review, the staff of the emergency department did not feel engaged in that process. Their views had not been considered in the planning and delivery of services and in shaping the culture of the service.

- The recent introduction of staff stories at trust board enabled staff to present their experiences. At the January 2017 meeting the sister on the stroke unit gave an account of dealing with an aggressive patient. Members of the board asked whether more support could have been given and heard what could make a difference in these situations such as improving conflict resolution training.
- Communication from the leadership team was at times felt to be lacking and not timely, particularly when decisions were being made in response to winter pressures and escalation. Examples given were the maternity ward being used for emergency patients and Cheddar ward not planning to open during the winter but then this happened quickly.

Innovation, improvement and sustainability

- Sustainability at Weston was a system wide discussion that the trust engaged in but aspects of learned helplessness appeared. The leadership and executive team were positive about the future although it was early days. There was recognition that the reputation view held by external people added to the challenges and that not all of the solutions to the strategic challenge was in the grasp of the trust board.
- The partnership working with University Hospitals Bristol NHS Foundation Trust was seen as an opportunity for nursing in advancing areas of practice and career development. It would also enable development of a joint service strategy, which could include a greater range of shared clinical and management services. Long term aims were for a formal agreement to help address long-standing issues of clinical and financial sustainability of Weston Hospital.
- The surgical directorate were engaged and working to meet the needs of the population through driving innovation. The gastroenterology service was looking to expand with collaborative working with the radiology department and good support from clinical nurse specialists.
- The trust was responsive to patients with mental health needs having good links with the mental health liaison team from the local Mental Health Trust. The team had built relationships within the hospital and delivered training and gave access to advice and support to staff. A mental health operational group run by the trust and attended by the mental health team met quarterly to share learning from incidents and complaints. One joint initiative was a flag on the emergency department system for frequently attending patients where information on what medication to not prescribe was recorded.

Summary of findings

- Improvements and developments remained on-going to enable the emergency department to be as safe and effective as possible. Collaboration with external partners to help improve patient flow included implementation of a public address audible system to alert staff when assistance was needed to include the reception area. Reception staff told us this worked well.
- A crowding dashboard plus action cards had developed and was available in the emergency department for staff to know if the level of escalation due to crowding had been reached. This tool had no link to the OPEL tool to escalate for wider action.
- An emergency department tracker role had been implemented. This member of staff tracked bed vacancies and liaised with the bed management team. This role had not been fully recruited to and was currently in its infancy.
- Concerns were raised about the lack of thrombolysis outside of Monday to Friday and stroke pathways, and no dedicated therapy staff on the stroke unit. Staff were pushing to introduce a stroke steering group to help provide innovation and improvements within stroke. There were plans for the senior stroke team to visit a local acute trust's stroke ward to see what good looks like.
- Since out last inspection the ambulatory emergency care unit was appropriately refurbished and high care patients were no longer on Harptree ward.
- There had been improvements in the critical care unit focused around patient care. These included:
  - Procurement and delivery of a difficult airway trolley to support safer intubations. Previously the trolley was borrowed from the operating theatres. The availability of a trolley on the unit was following a recommendation of the National Confidential Enquiry into Patient Outcome and Death review of tracheostomy care 'On the Right Trach?' from 2014.
- Critical care had designed and brought into use a small crash bag. This was a portable set of equipment, which could be easily carried and was portable for use on the wards and in the emergency department. A member of the critical care team would take this bag with them to any crash calls within the hospital to ensure all equipment that might be required was immediately at hand.

Overview of ratings

Our ratings for Weston Area Health NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	Good	Inadequate	Inadequate	Inadequate
Medical care	Requires improvement	Requires improvement	Good	Inadequate	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Requires improvement	Good	Good
Critical care	Good	Good	Good	Requires improvement	Good	Good
Overall	Requires improvement	Requires improvement	Good	Inadequate	Requires improvement	Requires improvement

Our ratings for Weston Area Health NHS Trust

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

Outstanding practice and areas for improvement

Outstanding practice

- The oncology and haematology department demonstrated good practice with the way they assessed patient risk. Patients with a risk of neutropenic sepsis were easily identifiable through the use of a yellow jacket placed on patient notes.
- Patients living with dementia were situated in the bays or side rooms that were most visible to the nursing station. Staff who provided enhanced supervision to these patients were wearing yellow tabards and were easily identifiable. Staff were allocated to a patient or a group of patients in a bay and were not to be removed unless another staff member had taken over from them. We saw the hospitals own 'This is me' booklet in the notes of a patient living with dementia. This booklet had been completed by a relative of the patient and explained the patient in detail, what they liked to be called what they liked to do, what was their favourite food.

Areas for improvement

Action the trust MUST take to improve

- Ensure that there are sufficient numbers of suitably qualified, competent, skilled and experienced doctors deployed within the hospital. This includes sufficient medical leadership within the emergency department and suitable levels of staff to ensure the corridor is safely staffed.
- Take action to ensure that there are sufficient medical staff with sufficient skills in advanced paediatric life support in the emergency department.
- Take action to ensure that medicine systems in the emergency department are safe for controlled drugs including signature list for agency nursing staff and locum doctors, to cross reference who had prescribed and administered medicines.
- Take action to ensure that systems are in place to ensure patient flow through the hospital was responsive.
- Ensure patients are being admitted promptly once the decision to admit has been made. Take action to ensure that safety checks in the emergency department are completed.
- Take action to ensure that patients are cared for in a safe environment in the emergency department.
- Review the medical staffing and ensure safe levels of medical cover and support to juniors on the medical wards in evenings and weekends.
- Review the use of locum consultants and take action to ensure medical staffing is not vulnerable through recruitment of permanent consultant staff.
- Be assured junior medical staff are being provided with appropriate support and are competent in their roles.
- Ensure safe nursing cover is provided on Cheddar ward and agency usage is kept to a minimum.
- Take action to mitigate risks included on the risk registers effectively, reviewing regularly and managing those risks identified on a timely basis to ensure safety to staff or patients is not compromised.
- Manage quality and performance and ensure sustained learning and improvements from audits.
- Take action to continually maintain a clear path for evacuation in the event of a fire within the stroke unit by ensuring fire exits are not blocked.
- Take action to ensure patient flow from the emergency department through the medical wards to timely discharge is effective and timely in meeting the needs of patents and ensuring good quality care and treatment.
- Take action to address areas of concern and demonstrate patient outcomes monitored by the Summary Hospital – level Mortality Indicator (SHMI) are improved.
- Improve the quality, attendance, accountability learning points and actions from mortality and morbidity reviews in all specialities.
- Make sure the surgical directorate has an orthopaedic-geriatric service for pre and post-operative care.
- Ensure all patients that had fractured neck of femurs were operated on in line with national guidelines and admitted to an orthopaedic ward within four hours.

Outstanding practice and areas for improvement

- Follow trust policy for the management of medicines, for example checking of controlled drugs, recording of medicine refrigerator temperatures and recording of signatures of agency nurses and locum doctors. (Accident and Emergency)
- Review pharmacy staffing levels in order to meet service, clinical and medicines governance demands and achieve medicines related CQUINS and Carter model hospital indicators and therefore protect patient safety.
- Ensure multidisciplinary input and a collective approach to the running of the critical care unit. The medical team leaders must ensure they meet regularly with the senior nursing leadership to provide a multi-professional approach and contribution to all aspects of running the unit, including governance and provision of quality care.
- Address the poor access and flow of patients in critical care in order to reduce the delays to patients who are fit to leave the unit, reduce the risks of patients not having timely admittance, eliminate breaches in same-sex rules, stop the relocation to or delay of patients in the operating theatre recovery area, and reduce the number of patients who are transferred to a ward bed at night.
- Produce mortality and morbidity reviews for critical care where there is accountability for learning and change, and a demonstration as to how this has improved practice and safety.
- Review the provision for and quality of life support training in the trust to ensure there are a satisfactory number of staff with the right experience and training on duty at all times.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care (1) The care and treatment of service users must – (a) be appropriate, and (b) meet their needs. Due to bed pressures elsewhere in the hospital, patients in the critical care service were not discharged in a timely way from the unit onto wards when they were ready to leave. There was a lack of facilities in the critical care unit to care for people and meet their needs when they were ready to be discharged, but delayed. Patients were also discharged too often at night. Although it was being safely managed, it was unacceptable that patients were being transferred to the recovery area in the operating theatres to make a bed available in critical care, or waiting there while a bed was being made available.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment (1) Care and treatment must be provided in a safe way for services users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include –

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Requirement notices

(b) doing all that is reasonably practicable to mitigate any such risks;

(c) ensuring that persons providing care and treatment to service users have the qualifications, competence, skills and experience to do so safely;

(d) Ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way.

(g) the proper and safe management of medicines.

At times, morphine was prescribed as a variable dose within the emergency department. Records did not should how much was administered or what happened to any unused drug in accordance with safer management of controlled drugs legislation.

There was no signature list for agency nursing staff and locum doctors, this meant that to cross reference who had prescribed and administered medicines was not possible.

Pharmacy staffing levels were not sufficient to meet the needs of the service including clinical and governance demands and ensure achievement of medicines related CQUINS and Carter model hospital indicators and therefore protect patient safety.

Escalation processes in place to indicate action when the department was under pressure were not responsive and did not affect a wider hospital support.

Patients are not able to responsively access the care they need. There has been a decline in patients being admitted promptly once the decision to admit has been made. The trust did not meet the target for patients to be

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Requirement notices

admitted within four to 12 hours of an admission decision being made. The method of calculation and process meant patients were in the emergency department longer than required.

In Critical Care there were an insufficient number of senior nursing and medical staff trained or updated in life support skills.

There was an environmental safety risk for both patients and staff.

Fire exits were observed to be blocked on the stroke unit. This was raised with management and the blockage removed. However, on our unannounced inspection we found the exit to once again be blocked. There was a lack of assurance this information had been effectively communicated to staff and the safety risk was being managed.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems of processes must enable the registered person, in particular, to - (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity, (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from carrying on of the regulated activity;

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Requirement notices

(c)maintain securely an accurate, complete and contemporaneous record in respect of each service user

The systems in place for checking emergency equipment was not robust. Daily checks of resuscitation equipment, blood and ketone monitor equipment were not consistently completed placing patients at risk in an emergency.

Fridge temperatures and controlled drugs were not correctly monitored according to the trust's own policy. This lack of consistent monitoring may place patients at risk.

Patient records were not all secure and posed a risk that patient confidentiality may be breached. This relates specifically to patients receiving care on the corridor.

The management of flow through the emergency department and wider hospital does not consider the risks to patients by extended length of stay in the emergency department.

There was a lack of a multidisciplinary and collective approach to running of the critical care unit. The medical team leaders did not meet formally and regularly with the senior nursing leadership to provide a multi-professional approach and contribution to all aspects of running the unit, including governance and provision of quality care.

There was a lack of accountability for learning and change in mortality and morbidity reviews in all services. There was no evidence to show how reviews, learning and change led to improved practice and safety.

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Requirement notices

Systems and processes through regular audits did not ensure the monitoring and improvement of the quality and safety of the service.

Findings from audits were not being shared across the trust to ensure learning and drive improvements. The trust was regularly underperforming in national audits against the England average, and there was a lack of assurance of improvements from these audits.

Risks were being identified, however they were not being managed effectively and in safe timescale.

The increased beds on the stroke unit had been included on the risk register in December 2016, this identified a risk to patient and staff safety due to fire exits being blocked. This risk had not been managed and we identified blocked fire exits during our announced and one of our unannounced inspections.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment (1) All premises and equipment used by the service provider must be - (c) suitable for the purpose for which they are being used. The use of corridor areas in the Emergency Department for patient care and treatment does not ensure patient safety. There is insufficient space, light and access to electrical supply.

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Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
The trust must take action to address serious failings to ensure quality care and treatment and safety of patients.	Systems or processes to manage patient flow through the hospital must operate effectively to ensure care and treatment is being provided in a safe way for patients and to reduce crowding in the emergency department. Review the emergency department as the single point of entry to the hospital for both emergency and expected patients to reduce crowding. Ensure access to a specialist senior doctor to review patients overnight in the emergency department is timely and does not delay patient admission to wards. Ensure the use of the corridor in the emergency department is an appropriate and safe area for patients to receive care and treatment.