University Hospitals Bristol and Weston NHS Foundation Trust

Weston General Hospital

Inspection report

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Date of inspection visit: 11 March 2021
Date of publication: 12/05/2021

Ratings

Overall rating for this service	Not inspected

Our findings

Overall summary of services at Weston General Hospital

Not inspected

Since April 2020 Weston hospital has formed a division of University Hospitals Bristol and Weston NHS Foundation Trust. This was the first inspection of this service since the change in registration. When a hospital changes management in this way, we would normally do a comprehensive inspection and give up-to-date ratings for all services. However, during the COVID-19 pandemic we have restricted our inspection activity, resulting in this being a focused inspection.

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

Because of the COVID-19 pandemic, patients had been grouped together (cohorted) on wards according to their COVID-19 status. This was due to an urgent operational necessity to cohort in accordance with infection control guidance. 'Green' wards were for patients who had negative COVID-19 tests results. 'Amber' wards were for patients who may have COVID-19. 'Blue' wards were for patients who were positive for COVID-19. Because of this, wards were no longer based on the specialty (for example, by cardiology, stroke or care of the elderly). Wards not only had medical patients on them, but also surgical patients.

The senior leadership team at Weston oversaw all specialties at the site – medical and surgical wards, outpatients, emergency department and critical care.

This inspection had a short announcement (one day) to enable us to carry out our work safely and effectively. The last time we inspected this service it was part of a different organisation. Therefore previous ratings do not apply. Due to the narrow focus of this inspection, we did not rate the service at this inspection.

Medical care (including older people's care)

Inspected but not rated

We inspected the medical care service to follow up on concerns raised about nursing and medical staffing, and the implications of these on safety. At this inspection we reviewed the organisation of the medical service at Weston – how it was led, how safe it was and the factors that contributed to this.

We found:

- The service did not have enough nursing or therapy staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. Gaps in planned staffing levels could not always be filled by agency or bank staff.
- The service did not have enough medical staff at all levels to meet the recommended guidance for the department or be able to develop the service. There were insufficient numbers of consultants in post. There was also a shortage of middle grade doctors.
- Whilst comprehensive risk assessments were mostly completed for patients that needed them, staffing shortages created a risk that deteriorating patients were not always recognised in a timely way.
- The service did not always manage patient safety incidents well. Staff mostly recognised incidents but did not always report them. Lessons learnt were not always shared with staff.
- The service did not always ensure staff were competent for their roles. Not all staff had the training to cover the scope of their work. Patients did not always have their assessed needs, preferences and choices met by staff with the right skills and knowledge.
- Leaders in Weston hospital did not demonstrate the capacity to run the service. They understood, but did not manage, the priorities and issues the medicine service faced. They were not always visible, or felt to be supportive or approachable in the service for staff. The trust senior leadership team were perceived not to be present enough on the wards to understand the issues staff faced.
- Staff did not know or understand what the trusts vision, values and strategy were, and their role in achieving them. The merger of the two organisations on 1 April 2020 and the plan for integration of the hospitals had been impacted by the COVID-19 pandemic. Staff told us there was little collaboration to create or understand the visions, values and strategy for the new organisation, and they did not know how they fitted into the structure.
- Staff in the service did not always feel respected, supported and valued. Staff were caring and focused on the needs of patients receiving care. This was despite feeling isolated and lacking supportive leadership.
- The culture in the hospital meant staff did not feel they could always speak out or they did not feel they had protection to speak out safely.
- Governance processes were not used effectively to monitor the quality of care and assess the ongoing performance, learning and development of the service. Staff at all levels were not clear about their roles or accountabilities. Opportunities to meet were not consistent and learning from the performance of the service was not always maintained.
- Although leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact, these were not used to prevent reoccurrence or promote prevention. Medical care was not managing issues early enough to prevent them from becoming problems.

However:

Medical care (including older people's care)

- Staff understood how to protect patients from abuse and acted on any concerns. Staff we spoke with understood the different forms of abuse and what action to take to promote patient safety.
- Staff on the wards we visited understood how to manage infection prevention and control and all areas were visibly clean. Staff wore appropriate personal protective equipment (PPE) to keep themselves and others safe from cross infection.
- Staff kept detailed records of patients' care and treatment. Records were clear, up to date, and easily available to all staff providing care. Patient records were managed securely.
- During the inspection we saw staff respond compassionately when people needed help and they supported them to meet their basic personal needs as and when required. They anticipate people's needs. Staff recognised the importance of people's privacy and dignity.

How we carried out the inspection

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Is the service safe?

Inspected but not rated

Safeguarding

Staff understood how to protect patients from abuse and acted on any concerns. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff understood the different forms of abuse and what action to take to promote patient safety. They explained how they would report safeguarding concerns and they could access the hospital's safeguarding team with questions or to seek additional advice when necessary. Staff were confident in the action they would take to ensure the patient's safety.

Cleanliness, infection control and hygiene

The wards we visited controlled infection risk well and they were visibly clean. Staff wore personal protective equipment (PPE) to keep themselves and others safe from the risk of cross infection.

Ward areas, including furnishings were visibly clean and mostly well maintained. Cleaning records demonstrated areas were cleaned regularly and in line with a planned cleaning schedule.

All wards we visited had side rooms, which enabled staff to treat and care for patients with confirmed or suspected infectious diseases. These rooms had clear signs on the doors or walls to restrict entry and had PPE available. This reduced the risk of cross infection to other patients on the ward.

Staff followed infection control principles, including the use of PPE. We observed most staff following correct use of PPE and required hand washing. Staff disposed of PPE in clinical waste bags. Staff told us they had no problems with accessing the PPE required to do their work safely and reduce the risk of infection.

We observed staff cleaning equipment after patient contact, and staff told us they would label equipment to show when it was last cleaned. We saw commodes in sluice rooms which were labelled with 'I am clean' stickers to alert staff they were suitable to be used.

Handwashing facilities and decontamination gels were readily available for staff and visitors to use. There were visible instructions at ward entrances which informed visitors to the ward of the importance and methods of hand cleansing and use of PPE. All staff we saw were bare below the elbow and decontaminated their hands between patient contacts.

Assessing and responding to patient risk

Comprehensive risk assessments were carried out for most people who used services and risk management plans were developed in line with national guidance. Staff mostly identified and responded to the changing risks to people who used services, including deteriorating health and wellbeing, medical emergencies or challenging behaviour. However, staffing shortages created a risk that deteriorating patients were not always recognised in a timely way.

Staff completed risk assessments for each patient on admission or arrival onto the ward, using a recognised standard tool. However, staff told us there were occasions where staffing shortages and operational pressures meant they were not always able to complete the assessments in a timely way. This created a risk because a delay in recognising concerns had the potential to cause harm to patients.

Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them when necessary. Staffing shortages risked having an impact on the early recognition of a deteriorating patient. Patients were monitored and assessed using the National Early Warning Score (NEWS) framework. This was a system of monitoring patient's vital signs, such as temperature, respiration rate, blood pressure and pain. A score was calculated, and actions were advised for nursing staff according to the score. Any patient whose condition was deteriorating could be identified and their condition escalated for further medical review. The six patient NEWS charts we reviewed were completed and acted upon. However, staff told us staffing shortages meant there were sometimes delays in completing NEWS charts and as a result there might be delays in recognising a deteriorating patient. Medical staff also told us low levels of nurse staffing meant patients with higher NEWS scores were not always escalated in a timely way.

Audit data was gathered but it was not clear how data was used to change or improve practice. Staff completed audits of the records of deteriorating patients every month, and we were provided with the audit results from December 2020 to February 2021. These audits looked at how a range of questions to assess patients at risk of deterioration had been completed. These included the scores being calculated correctly, being on the correct scale of oxygen, pain scores being checked every four hours, and assessment for sepsis. An audit of the use of tools used to assess patient risk showed repeated areas that had not been addressed or improved, for example sepsis screening. We could not therefore be assured that audits were being used to drive improvements in this area.

We found all laboratory results (such as results for dermatology and histology) were sent to one consultant, rather than to the consultant who ordered the results. This meant the consultant receiving the results had to spend time ensuring these results were sent on to the correct consultant. Staff were extremely concerned there was a potential of missing important results which would impact on treatment timescales. We were told this had been escalated many times and noted in local governance minutes but was not included on the risk register and identified for action.

Medical care (including older people's care)

Staff kept clear records which included the patients' risk of infection, risk of falling, mental health, dementia, venous thromboembolism, and pressure ulcers assessments. Once patient risks were identified, care plans were developed to inform staff of the individual care and treatment the patients needed. Records seen showed staff reviewed the risk assessments and associated care plans regularly, including after any incident or change in health needs.

Patients were not all cared for by staff with the specific skills to meet their needs. In line with guidance and other trusts, the hospital had reconfigured wards to accommodate COVID-19 patient pathways. All wards we visited had medical and surgical patients instead of separated as medical or surgical speciality areas. Surgical patients were looked after by surgical doctors but not always by nurses experienced in surgical care. Patients requiring medical care received treatment from doctors in the medicine speciality but could sometimes be cared for by nurses whose experience was with surgical care.

The reduced levels of staff had an impact on patient care. Nurses recognised incidents such as patient falls and pressure ulcers had increased, due to the pressure of staff shortages. We saw that half of the trust's reported hospital acquired pressure ulcers, and 32% of the trust's reported patient falls resulting in harm were at Weston hospital. were at Weston hospital. A trust review of nurse staffing in January 2021 analysed patient safety incidents. This showed that many incidents were due to lowered staffing because of COVID-19 staffing numbers. Some shifts were below the expected levels of staffing, and this had been agreed after a risk assessment had occurred.

Nursing staff told us it was very hard to prioritise care when they had high acuity patients as there were often insufficient staffing levels.

Patients at the end of life were cared for using side rooms when possible. Staff had sufficient skills to meet their needs. Staff were supported by a palliative care team who visited wards regularly.

They had close working relationships and were able to support staff, patients, and relatives when patients were reaching the end stage of their life. When patients with end of life needs deteriorated systems functioned to access medicines and equipment to enable them to remain comfortable.

Nurse staffing

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

There were considerable staff shortages caused by the Covid-19 pandemic. The COVID-19 pandemic brought pressure to all hospitals in the country due to staff either becoming infected, being required to self-isolate after contact with a positive person, or from more routine sickness. There was also pressure from patients needing more care, PPE taking time to put on and remove, and a reduction in the availability of temporary staff. This compounded with a shortage of nursing staff at Weston before the pandemic created an increased risk to both patients and staff.

Staff did not understand some decisions made about how they worked. Like many other hospitals during the pandemic, ratios of staff to patients were adapted to account for the increased numbers of patients being admitted into hospitals, and to reflect higher staff absence due to shielding or staff sickness. Prior to the outbreak of COVID-19 there had been a ratio of one registered nurse to every six patients during the day, and one to every eight patients during the night. During the pandemic this was changed to one registered nurse to eight patients during the day, and one to 12 patients during the night. We saw staff were informed of the changes to staffing numbers by email from the Chief Nurse and Divisional

Head and we were told the information was cascaded through the matrons and ward sisters. Ward sisters amended ratings for their wards in response to the changes in staffing ratios. However, it was clear during our inspection staff had not understood the new ratios. Many members of staff told us they were caring for more patients than usual but were not aware this had been a hospital-wide decision or how this decision was reached.

There was a high number of temporary nursing staff needed to fill vacant posts. Vacancy rates for band five nurses at the time of the inspection was at 28%. This meant that nursing staff vacancies in conjunction with staff sickness left the remaining nursing staff under considerable pressure.

Not all ward areas had enough nursing staff available to meet patient's needs. The trust provided us with nurse staffing data for January 2021. This data showed the overall 'fill rate' (how many shifts were filled) across the hospital was 70% of the total amount of nurses needed. For registered nursing staff this was 69% during the day and 61% during the night. For healthcare assistants, the fill rate was 95% during the day and night.

During the same period there was an average 15 registered nurses and 13 nursing assistants absent per day across the inpatient wards due to COVID-19 related illness. This put additional pressure on nurse staffing on the wards.

Staff were concerned about the staffing levels. Some staff said the way the services had been reconfigured to COVID-19 pathways meant staff were spread too thinly to ensure patient safety. The lack of staff meant they did not always feel the right standard of care was being given. Some staff told us the volume of work was a worry for them.

Senior nursing staff were clear nursing staff had worked exceptionally hard in very difficult circumstances, staff on wards supported each other well, and there was supportive team working. There had been a recent international recruitment drive for nurses, and senior staff were hopeful this would ease the nursing shortfalls on the wards.

Ward managers told us they were keen to work with their registered nurses and healthcare assistants to develop their skills and provide training, but this had been a challenge because of staff shortages.

Medical staffing

The service did not have enough medical staff to meet the recommended guidance for the department.

The shortage of medical staff impacted on the service provided. There were not enough substantive consultants within the medicine service at Weston hospital to ensure there was enough time for patient review and for the required support of junior staff. The service had only with only four substantive consultant posts out of 12 filled. One of these substantive consultants was on a career break. Additionally there was a consultant on an NHS secondment, one on an NHS fixed term contract plus seven locum or bank consultants. For registrars there were only nine out of the required 15.

As a result of insufficient numbers of medical staff, some wards did not have the full complement needed to provide safe cover and the required support to junior doctors. The trust had assessed medical staffing gaps based on minimum staffing levels. The data showed most shifts from 1 November 2020 to 31 January 2021 were below the trust's own minimum staffing levels. During this period, we saw there had been a large disparity between the number of medical staff on each ward against the guidance. On Berrow ward, there had been 12 days where there had been a shortage of medical staff, and on Harptree ward there had been 18 days where there had been a shortage. On Cheddar ward there had been 57 days where there had been a shortage of medical staff, and Sandford ward 47 days with a shortage. These minimum staffing levels included consultants, middle grade doctors and trainee doctors. As a result, the information provided did not enable us to assess the number of consultants available each day on each ward to provide leadership, support and clinical expertise.

Medical care (including older people's care)

The trust leadership implemented a system to manage consultant workload and behaviours. The leaders acknowledged consultants needed to act more flexibly, improve the supervision of trainee doctors, and also to improve how they worked on the wards, and ensure of behaviours consultants was in accordance with professional standards. On 15 February 2021, a standard operating procedure (SOP) was introduced to describe the "mechanisms for the allocation and recording of consultant responsibility for wards and patients and the monitoring mechanism for professional standards". This aimed to ensure there was a named consultant physician for every medical patient admitted to the hospital, and to ensure each ward had at least two full ward rounds per week where patients were seen by the consultant and board rounds on other days where patients were reviewed. All new admissions would be seen by a consultant within 24 hours of arrival on a new ward. The leadership team acknowledged this SOP was required to help to manage underperformance, and were planning to use the SOP to audit compliance, and manage underperformance.

At the time of our inspection Health Education England had raised concerns about the supervision of trainee doctors on medical wards at Weston hospital. Although there had been some improvement in the supervision of trainee doctors during the day, the levels of supervision out of hours continued to cause concern.

We found on-call rotas were prioritised as the most important shifts and as a result were filled, however this was often very last minute and at the expense of daytime rotas. On-call rotas are a work schedule in which consultants work a normal day, Monday to Friday, and are "on-call" in rotation for the rest of the 24-hour period and for weekends. Day time rotas would be left empty to ensure on call shifts were filled. Doctors questioned whether one registrar working overnight was enough and told us a business case had been put forward for an additional registrar rota slot, but the leadership team had declined the business case.

We found there was no person who was responsible for the overall running of on-call and day-to-day allocation of trainees to wards. This led to last minute discussions and arrangements for working shifts, for which trainee doctors took ownership. However, this was not an effective way for allocating staff to rotas.

There were not enough registrars to cover the medical wards at Weston. There were nine registrars to cover the medical wards, which left six vacant posts. We were told the registrars were often managing patient outliers and so were not accessible or available (an outlier is a hospital inpatient who is classified as a medical patient but has at least one move to another ward during their hospital stay), and there were times when one registrar would be required to cover two wards.

Staff described the organisation of wards into COVID-19 groups instead of specialties created confusion, disorientation, and disorganisation at all levels of the medical and nursing workforce. Wards had a mix of patients from general medicine, cardiology, surgery, and orthopaedics, which created confusion for staff, and it was not always clear which patients had been seen by a medical team. Medical staff were unclear who was responsible for each patients' care and treatment. It also meant there was unclear accountability or responsibility held by the medical workforce for individual patients and did not ensure safe continuity of care for these patients.

The lack of consultant availability impacted on the support available for trainee doctors. Health Education England (HEE) had noted there was a need for significant improvement to clinical supervision for the foundation year one trainee doctors. As a result of the concerns raised by HEE trainee doctors told us there had been an improvement to clinical supervision during the day, and this improvement in direct supervision had given them the ability to escalate any concerns relating to patients. However, they still had concerns regarding out of hours access to clinical support. We were given examples of consultants taking over 40 minutes to arrive into the hospital at night, and occasions were where

phone calls to senior doctors were not answered on either the first or second call. Trainee doctors told us some consultants were approachable and supportive during the day but also very busy, they often lacked a registrar for daytime provision which would have normally provided the support required. However, this support was also lacking out of hours (at night, weekends, and public holidays).

The trust had recently introduced a 'hospital at night' team, a multi-professional, multispecialty approach to delivering care at night and out of hours, with the aim of improving patient safety. It involved members of medical and nursing staff coming together to form a team that managed patients across many disciplines in a hospital. The hospital at night team had been able to support the trainee doctors, this included support with complex procedures, for example non-invasive ventilation (NIV) (the delivery of oxygen (ventilation support) through a face mask). However, this was not always effective as any sickness in the team, or incidents elsewhere in the hospital, could compromise the ability of the team to fully support trainee doctors at night.

Registrars told us there was a lack of access to training opportunities in their own specialty as they were required to cover multiple general medical duties and ward rounds during their day and there was not the time to dedicate to training.

The hospital had employed locum doctors (non-substantive doctors who did not have a permanent contract) to fill the staffing gaps. Whilst a significant number of locum doctors had been in post for a long time and therefore the work force was generally stable, a lack of substantive staff meant that the department could not plan well for the future.

Records

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

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

Records were well maintained. We reviewed six sets of patient notes, all were maintained to a good standard from both the nursing and medical teams. They were clearly written and recorded timely reviews of patients. The safety checklist was completed by nursing staff each hour for all those patients we reviewed. Medication records we reviewed showed medicines were given in a timely manner and accurately recorded.

Incidents

The service did not always manage patient safety incidents well. Staff mostly recognised incidents and but did not always report them. Lessons were not always shared with staff.

An electronic incident recording system was available but was not consistently used by staff. Staff were aware of the electronic incident reporting system. However, many staff told us they did not always enter incidents on to the system, because they often lacked time to complete the database. They also told us they often did not get feedback on incidents reported and so were not aware of any action taken or learning shared. Medical staff told us they were more likely to receive feedback following incidents; feedback was given following some incidents at debrief sessions and the posters were put up in the doctors' mess. However, nursing staff had less time to attend meetings and many told us they did not receive any feedback or hear of any learning following incidents.

We identified there had been 788 incidents reported from 1 December 2020 to 9 March 2021 relating to medical care. Of these 668 were reported as no harm, minor harm, or negligible harm.

Medical care (including older people's care)

185 incidents were still being reviewed or awaiting review, and of these 57 were in the most recent month. The trust policy for closing incidents was within 30 days. This meant that 23% of the incidents reported were not closed in line with the trust's own requirements. The most reported incidents were:

- Infection control: 134
- Staffing: 120
- Patient falls: 104
- Tissue viability: 70

Of the 120 staffing incidents, 25 related to doctors and 88 to nursing. 48 staffing incidents had red flags. This meant the minimum numbers of staff according to the standards within the reporting system of one registered nurse per eight patients during the day and 10 patients at night. However, the standard for registered nurses at night did not match the policy for staffing patients agreed during the pandemic, which had been adjusted to one registered nurse per 12 patients at night.

When reviewing the incidents we noted that actions taken in relation to incidents did not always managed the risks identified.

Leaders had audited 78 reported medicines incidents at Weston hospital between November 2020 and January 2021, 19 of which were still open on the date of our inspection. Identified themes included five incidents relating to poor discharge summaries, four incidents of a drug for a named patient being given to other patients, and three incidents relating to insulin. This audit recognised staff needed to ensure they were able to log on to the incident reporting system, and acknowledged reporting needed to be improved. There was also a recognition that incidents must be investigated and closed more quickly to enable a timely learning process to improve patient safety.

Staff understood the duty of candour. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation, which was introduced in November 2014. This regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. Staff told us when things went wrong, staff apologised and gave patients honest information and support. Staff were aware of this legislation and demonstrated a good understanding of their responsibilities to their patients under this legislation. Staff at all levels were able to describe what the duty of candour involved the actions required and where to look for guidance on the hospital's intranet if needed.

Is the service well-led?

Inspected but not rated

Leadership

Leaders in Weston hospital did not demonstrate the capacity to run the service. They understood, but did not manage, the priorities and issues the service faced, and they were not felt to be visible, supportive or approachable in the service for staff. The trust senior leadership were perceived as not present enough on the Weston site to provide assurance or demonstrate awareness of the risks and challenges faced by the medical service at Weston hospital.

Medical care (including older people's care)

The Weston division of University Hospitals Bristol and Weston NHS Trust was led by a divisional director, a head of nursing, and a clinical chairperson, a triumvirate that had been in place since the creation of the Weston division in April 2020. This senior leadership team oversaw all services running from the Weston hospital site. They told us about the challenges facing the hospital as a division and they recognised staff had been under significant pressure.

The hospital leadership team had not used governance systems and data well to address potential issues. They recognised as a division they had been reactive to issues as they occurred rather than proactive. There had been delays in recruiting into the management structure, but a deputy divisional lead in medicine and deputy lead in surgery had been recently appointed. They accepted that the new team structure was in its infancy and previous systems had not been adequate.

The leadership team also told us they lacked the capacity to deal effectively with some of the issues and had become remote to the hospital workforce. Weston had mostly been a 'blue' hospital with six 'blue' wards, which meant they mostly had patients with confirmed COVID-19. This led to significant operational pressures including infection control, and cohorting of patients with a small number of beds available. There had also been two COVID-19 outbreaks (two or more test-confirmed cases of COVID-19 with illness onset dates within 14 days of each other), which led to diverting patients away from the hospital. The leadership team told us they had not been able to visit the wards as they would have liked during the pandemic. This was described as being due to the pressures of the work, the impact of COVID-19 and not wanting to put patients at risk. Staff at all levels across the medical wards confirmed they had not seen the leadership team for months. Many staff told us they would not know who the leadership team were. Staff were very disheartened by this and felt 'abandoned' by the leadership team, telling us how grateful they would have been if leaders could have come on the ward, even to help answer phones, or with cups of tea.

The divisional leadership team told us about a social media platform, The Voice, which was a forum for staff to contact and communicate with them. They recognised this was not working effectively and noted staff were using another social media platform to stay in touch with each other. There was a recognition that use of the other social media platform was unofficial and whilst it contained positive feedback it was unmonitored and had therefore become unstructured and did not allow for responses by the leadership team. The leadership team had not tried to reach out to staff using other communication methods despite acknowledging the ineffectiveness of 'The Voice'.

There was a disconnect between the executive team and the wider workforce. Many staff we met could not recall seeing trust executives or non-executive directors on the wards. Executives from Bristol visited Weston hospital every week, but staff who were aware of this told us the executives worked from the divisional leadership offices and did not come on to the wards. The exception to this was the newly appointed interim chief nurse. She had met with representatives of the nursing team after staffing issues had been raised. Nursing staff talked positively about this and expressed hope that this was a positive leadership step for the future. Trainee medical staff also spoke highly of the visibility and responsiveness of the deputy medical director, who had been transferred into the division for in January 2021.

Vision and strategy

Staff did not know or understand what the vision, values and strategy were, or their role in achieving them.

The merger of the two organisations on 1 April 2020 and the plan for integration had been impacted by the COVID-19 pandemic as there had been some slippage in the integration of clinical services due to the need to focus on operational pressures. The trust had an implementation plan which outlined the requirements and stages for the integration of clinical and corporate services.

Medical care (including older people's care)

Staff told us there was little collaboration between the leadership and the workforce to create or understand the visions, values and strategy for the new organisation, and how the Weston division fitted into the structure. They did not know what the plans for the future were in context of the merger. They said there had been limited or no opportunity to meet up to be involved in, contribute to or discuss plans and as a result people felt 'done to'. There was a level of resentment by ward staff about being told to do things 'the Bristol way', and a lack of acknowledgement of where Weston performed well and learning could be shared across sites.

Culture

Staff did not always feel respected, supported or valued. Staff were caring and focused on the needs of patients receiving care. This was despite feeling isolated and lacking supportive leadership.

At ward level staff felt supported and listened to but there was a disconnect between the ward level staff and the senior leadership within the hospital.

There was a Freedom to Speak Up Guardian based at Weston hospital, and staff told us they were accessible. However, staff described a culture in the hospital where they did not feel they could always speak out, or that they had any protection to prevent repercussions if they raised concerns. They also told us senior management were not available to listen to concerns or resolve the problems. There were communication issues for all staff groups we spoke with. This led to a lack of understanding of the causes of the issues, and no confidence issues would be resolved. This contributed to a fear of speaking up because there was no confidence issues would be managed fairly.

We found cultural problems with the behaviours of a significant number of medical consultants. For some this meant that they were not visible or approachable. For others, long standing behaviours required management. The trust had introduced the standard operating procedure in part to ensure twice weekly ward rounds were completed and to manage the behaviour of consultants. There was no evidence that the behaviour of these consultants had been previously tackled, rather the effects of these behaviours had been mitigated through workarounds. This had, at times, masked behaviours or allowed them to continue unchecked and unchallenged.

All staff members we asked described a lack of communication as being a problem. They provided us with number of examples, such as how the changing of the use of wards and COVID-19 bandings was communicated extremely poorly. Nursing staff gave us examples of coming into work and finding the ward they worked on had changed its use overnight. Although they understood the need for flexibility, this had not been communicated to them so they were prepared for the day.

Many staff were using two emails systems. New email addresses had been issued to all staff on 1 April 2020 when the two organisations merged. However, staff told us they were having many problems accessing the new systems or merging with the old system. This meant they had to use both systems which was both frustrating, time consuming and there was a risk of information not being received in a timely manner. We saw that staff had been sent a number of emails on how to resolve this issue, but as some staff could not access these emails, this had not resolved the issue.

The main way staff were kept informed of changes was via through emails, and through a dedicated divisional internal website. However, staff told us they found it difficult to find time to read these with their workload, with the added issue of having to use both email systems.

Consultants told us they had made suggestions to the divisional leads to improve recruitment, but actions had not been taken. However, the leadership team could describe the actions taken to improve recruitment, this meant communication had not been maintained to inform consultants of actions taken.

Medical care (including older people's care)

Nursing staff told us team working on the wards was a good experience. On Harptree ward there was an 'Appreciation Wall'. Staff on all wards told us team working had been fantastic, and told us of positive relationships with ward managers, and of open-door arrangements so staff could speak to their immediate manager. On Kewstoke ward wellbeing conversations had been held the week prior to our inspection. This was appreciated by staff, as there had been an emotional toll due to the pandemic.

Many of the trainee doctors we spoke with told us they did not have enough support, and some senior medical staff were not always present and not always approachable. Many of the trainee doctors we spoke with told us they felt like they didn't have enough support - particularly out of hours, (although during daytime hours this was recognised to be improving), that they felt vulnerable and that senior medical staff were not always present enough and were not always approachable. Yet, at a more senior level, (consultant and upward) it appeared that the concerns of junior doctors were not clearly grasped. Despite these concerns having been raised, consultants and the senior management team had not taken accountability for addressing them until raised as a significant concern by other stakeholders. However trainee doctors also spoke positively about the support they had from each other, and from some of the consultant workforce. They told us there was a camaraderie, where doctors were able to organise themselves, wind down or just talk about anything outside of work.

Following the arrival of the deputy medical director into the division at the end of January 2021trainee doctors had been given access to the Happy App. The Happy App is an interactive web-based tool to gather real-time feedback from staff. Staff could use it to indicate how happy they were at work and record why. The deputy medical director monitored this to help understand staff satisfaction and engagement, and then acted on issues raised. The trainee doctors told us this showed a picture of the stresses of what had been going on, and this was used, on occasion, instead of using the incident reporting system. They told us they got a much more immediate response using the Happy App. We reviewed comments on the Happy App. We saw there had been 38 comments left by trainee doctors. They were able to rate the mood as either 'happy' (five responses), 'neutral' (four), or 'sad' (29). We saw each entry had been reviewed and a response made to that member of staff. The most common themes were about workload, rota design, clinical supervision, and supportive environment.

Governance

Governance processes were not effective in developing the service. Staff at all levels were not clear about their roles and accountabilities. Opportunities to meet were not consistent and learning from the performance of the service was not always maintained.

Systems used to monitor the quality of the service were not effective enough to guide leadership decisions. We were not assured leaders at Weston hospital had the information they needed to take actions to mitigate risks because the governance arrangements were insufficient. There appeared to be a lack of capacity at senior leadership level at divisional level to think strategically or enable a form of governance that supported the leadership. We heard the term "firefighting" on numerous occasions to describe a reactive response to issues rather than using governance to be proactive.

Staff were not engaged in the governance processes. Medical staff told us although staff numbers were increasing, they could not support clinical work as well as governance due to capacity constraints caused by insufficient staffing. However it was the responsibility of ward consultants to organise a weekly governance meeting for their designated wards.

There was a disconnect at divisional level so information did not transfer from ward to board and back again. For example, the divisional leadership team described actions taken to improve recruitment, including a safer staffing

review in 2018. Job plans were being written, but these had been delayed because of the merger. However, the consultants we spoke with were not aware of this and stated they had made suggestions to recruit registrars but had been ignored. We saw there was a lack of a system where staff working on wards could raise their concerns to be heard by senior leaders and executives. Staff talked about systems at ward levels, such as safety huddles, and meetings to give trainee doctors feedback, structured audits, and supporting for other. However these processes were not strong enough to support organisation wide governance. We had examples of recruitment issues which were understood by medical staff and senior managers, but a lack of communication through governance meant a lack of understanding on both sides of any actions taken. We also saw decisions taken at ward level could not always be maintained. Consultants gave examples of pathways and risk assessments they had developed which had been ignored by the senior leadership team. This was because the lack of a working governance system meant the senior leadership team were not aware of decisions taken and therefore were unable to support them.

Governance systems were not used to support the development of a quality service. Although it was acknowledged by managers that governance systems needed to be improved, there was no evidence systems were regularly reviewed or any plans were put in place to support improvement. There was also a lack of understanding about key performance indicators (KPIs) to keep patients safe. Performance indicators are used in hospitals to examine and compare performance. These indicators focus on areas such a length of stay, mortality rates, readmission rates and support the understanding and improvement of quality care. However, the consultants described KPIs as just mortality, decision making and complaints.

The role of guardian of safe working hours had been vacant and no governance system had been used to review the information in that time. This post had been vacant at the hospital from April 2020 until November 2020. The hospital recruited a guardian of safe working hours (GOSWH) in November 2020. The GOSWH remit was to reassure trainee doctors and employers that rotas and working conditions were safe for doctors and patients. They also oversaw the work schedule review process and sought to address concerns relating to hours worked and access to training opportunities. The GOSWH was required to provide quarterly reports to the trust board to provide assurance trainee doctors were safe and able to work, identifying risk and advise boards with the required response. We noted no GOSWH paper regarding Weston had been received by the trust board since the merger in April 2020.

The system to monitor working hours for trainee doctors was not consistently used and therefore did not inform any changes in practice. We reviewed a summary paper regarding Weston hospital trainees covering the period November 2020 to January 2021. This included a summary of all the times trainee doctors did not work to their planned working hours. This is called exception reporting where trainee doctors can log the times they do not work to their planned working hours. The exception reports (for all trainees in Weston not just those in medical care) included 42 for hours of work and five for the pattern of work. The top three reasons for exception working were:

- Leaving late due to high clinical workload on medical wards
- Completing time sensitive tasks not appropriate to handover
- No breaks taken during day plus extra time worked due to SHO being redeployed

Not all the trainee doctors we spoke with could tell us who their GOSWH was, and some did not know how to log in to the system to complete an exception report. We were not therefore assured that this system provided a reliable source from which senior leaders could draw information relating to the worked experiences of the trainee medical workforce.

Managing risks, issues and performance

Although leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact, these were not always revisited in times of crisis.

Medical care (including older people's care)

The management of risk did not ensure that those risks known were acted on or that learning was taken for future practice. The trust provided us with the risk register for the Weston division. We noted a high number of risks had not been reviewed by the target review date. This meant we could not be assured that risks were treated with the required urgency or acted upon promptly. Of the 332 risks relating to the Weston division, 136 were due to be reviewed in 2019 or 2020. This included 37 ‘very high risks”

Leaders and all staff we spoke to felt a key risk was around the nursing and medical workforce staffing levels which was present on the risk register. Recruitment to these posts had been a long-standing issue at Weston hospital. The risk that medical staffing would not be at the required numbers and the division was unable to recruit enough registered nurse at Weston hospital were both rated as very high risk on the risk register.

However, we also found risks staff shared with us which were not on the risk register. For example, this included many staff were using two emails systems (as reported above). A further risk identified but not included on the risk register was that all laboratory results (as reported above) were sent to one consultant, rather than to the consultant who ordered the results. We were additionally concerned that this created a risk of an information governance breach as the service could not be assured that the information was reaching the correct clinicians, and therefore the information was reviewed by a member of staff who did not need to see the result. an unauthorised access to personal information. There was no evidence of action being taken and the potential for an information governance breach had not been investigated.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

The medical care service must:

- Ensure there is enough staff to safely care for patients at all times.
- Ensure all staff received the required amount of supervision for their role to enable them to practice safely.
- Ensure there is adequate cover and support for the medical workforce at all times, including out of hours to be assured a safe service can be provided to patients which is subject to audit in order to provide assurance.
- Ensure incidents are investigated without delay and demonstrate learning is shared to mitigate the risk of reoccurrence.
- Ensure governance systems work effectively to support leaders to make sustainable proactive improvements.
- Ensure management of behaviours in accordance with professional standards.
- Review the risk register to ensure all risks are recorded and given priority to match their degree of seriousness.
- Ensure all information is handled in line with information governance requirements.
- Ensure laboratory results are sent to the consultant who ordered the tests.

The medical care service should:

Medical care (including older people's care)

- Consider how to address the perception on medical wards that there was limited senior and executive visibility, recognition, understanding and support.
- Develop systems so staff feel able to contribute their ideas and escalate concerns without fear of retribution.
- Improve communications channels so staff are fully aware of the hospital and department's vision, or changes to the service.
- Consider how to improve staff reporting of incidents.
- Provide support to trainee doctors for rota coordination.
- Improve engagement with the guardian of safe working hours with trainee doctors.
- Provide support to staff so they can merge their emails and use one system.
- Evaluate and consider the extent to which the culture of working environment is having a detrimental effect on staff and establish a plan to improve culture on wards.

Our inspection team

The team that inspected the service comprised a CQC (Care Quality Commission) lead inspector and another inspector, as well as two clinical fellows. The inspection team was overseen by Amanda Williams – Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing