University Hospitals Bristol and Weston NHS Foundation Trust

Inspection report

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Ratings

Overall trust quality rating	**Good**
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Outstanding**
Are services responsive?	**Good**
Are services well-led?	**Good**
Combined quality and resource rating	**Good**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

We award the Use of Resources rating based on an assessment carried out by NHS Improvement. Our combined rating for Quality and Use of Resources summarises the performance of the trust taking into account the quality of services as well as the trust's productivity and sustainability. This rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating.

Overall summary

What we found

Overall trust

Overall summary - Trust

The merger of University Hospitals Bristol NHS Foundation Trust and Weston Area Health NHS Trust took place on 1st April 2020. This was the coming together of these organisations to form University Hospitals Bristol and Weston NHS Foundation Trust (UHBW). When a trust acquires or merges with another service or trust in order to improve the quality and safety of care, we will not aggregate ratings from the previously separate services or providers at trust level for up to two years. Therefore, we have rated services at Weston General Hospital as this inspection. However, these ratings do not form part of the Trust's overall current rating.

The merger of the two organisations and the plan for integration of the hospitals had been significantly impacted by the COVID-19 pandemic. For the periods, 30 January 2020 to 31 July 2020 and 5 November 2020 to 25 March 2021, the NHS was in a level 4 emergency incident. This meant that the Trust was subject to national command and control directives and procedures. Plans were put on hold to allow efforts to be focused on the response to the pandemic and integration had not happened as quickly as planned.

The previous ratings for the former Weston Area Health NHS Trust no longer apply and a new rating for the Weston General Hospital location, under UHBW has been given following this inspection.

Our findings

On 8 and 9 June 2021, we carried out an unannounced inspection of the trust's medical care service at both the UHBW Bristol main site and Weston General Hospital. We also carried out an unannounced inspection of the trust's outpatients service at Weston General Hospital. We spoke with 238 members of staff including members of the senior leadership team, nurses, doctors, managers, allied healthcare professionals, housekeeping and support staff. We also spoke with 51 patients and two visitors and reviewed 59 sets of patient records.

We also inspected the well-led key question for the trust overall. During the well led assessment we undertook a number of staff focus groups including junior doctors, clinicians, divisional directors, nursing sisters and staff representative groups.

At our last comprehensive inspection of University Hospitals Bristol NHS Foundation trust, undertaken in 2019, the trust was rated overall as outstanding.

In February 2021, we carried out a focused inspection of the Bristol Royal Infirmary (part of UHBW Bristol main site) urgent and emergency care service for adults (also known as accident and emergency or A&E) as part of our winter pressures inspection programme. A number of concerns were identified during this inspection. Notably, the service did not have enough medical staff to meet the recommended guidance for the type and size of the department or to be able to expand the service. The trust senior leadership were perceived by some staff as not having been present enough in the department to provide assurance and support, demonstrate recognition and awareness of the risks. Senior leaders were not sufficiently visible and approachable for some staff. There were serious concerns among the staff about the escalation in violence and aggression on staff working in the emergency department and the lack of action to resolve this over many months.

During that inspection and our current well led assessment of the trust, a number of staff contacted us expressing safety concerns caused by insufficient staffing levels. They described some care and treatment which was not of satisfactory quality or safety due to serious concerns around flow, performance, crowding, and timely access to safe care. Although we recognise demand for A&E services was under intense pressure, concerns remain about the trust leadership, management, and ability to support the department through this difficult time.

We undertook an inspection of medical care at Weston General Hospital in March 2021 focusing on the safe and well led key questions. Our inspection resulted in a number of concerns and led to us requesting immediate (same day) assurance about staffing levels for the following weekend.

A Letter of Intent to potentially undertake further enforcement action was also issued. An action plan was provided by the trust to explain how the risks were to be mitigated and managed. For an initial period of three months, beginning in April 2021, we increased the level of engagement with the trust to discuss the actions taken in the medical care service at Weston General Hospital.

During our core services element of this inspection, undertaken on 8 & 9 June 2021 we were significantly concerned about the safe care and treatment of patients receiving medical care at Weston General Hospital and imposed urgent conditions upon the trust's registration. Within these urgent conditions, the trust was required to take urgent action to protect patients who will or may be exposed to risk of harm. We made this decision for the following reasons:

- The trust had not assured those patients were receiving care and treatment in a ward or department to meet their clinical needs.
- The trust did not have sufficient medical and nursing staff to meet the needs of patients.

Our findings

- There was no effective clinical leadership to ensure the patients not exposed to the risk of harm.
- Leaders in Weston General 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.

These were issues raised at previous inspections undertaken by us during the past six months.

The provision of training at Weston General Hospital for trainee doctors has been the subject of some 18 triggered visits by Health Education England (HEE) and the General Medical Council (GMC) since 2012. Much of the focus has been on clinical supervision including that of FY1 trainee doctors (although eight years of this time period related to the former provider of this service).

Following a quality intervention visit undertaken by HEE on 21 January 2021, three immediate mandatory requirements were raised to ensure immediate access to senior, patient facing, clinical supervision for foundation year one (FY1) trainee doctors. This was in response to evidence that these trainees were still not being adequately supervised as they managed patients in the department of medicine. In April 2021, due to continuing concern, HEE made the decision, supported by the GMC, to relocate 10 FY1 trainee doctor posts in medicine out of Weston General Hospital to the Bristol hospitals within the trust.

Following this inspection in June 2021, the ratings for both the core service inspections and the well led assessment deteriorated.

For medical care at University Hospital Bristol and Weston, we rated the main Bristol site as requires improvement for safe, this is a deterioration as this was previously rated as good. We rated the key questions of effective, caring and responsive and well led as good and the overall rating was good

For medical care at Weston General Hospital, we rated the key questions of safe and well led as inadequate. We rated effective and responsive as requires improvement. Caring was rated as good. Overall, the medical care service was rated as inadequate.

For outpatients at Weston General Hospital, we rated safe, caring, effective and well led as good. Responsive was requires improvement and overall, the service was rated as good.

We rated well-led for the trust overall as Good.

We did not inspect a number of core services at both the Bristol and Weston locations. We remain monitoring the progress of improvements to services.

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

What we found – Medical Care – UHBW Bristol main site

Our rating of this service stayed the same. We rated it as good because:

Our findings

- The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and staff were committed to improving services continually.

However:

- The service provided mandatory training in key skills to staff but not all staff had completed it.
- Premises were not always being used for their intended purpose. For example, additional bed spaces added to wards could compromise patient care and privacy.

What we found – Medical Care – Weston General Hospital

We rated it as inadequate because:

- The service did not always have enough nursing and medical staff to care for patients and keep them safe. The service provided mandatory training in key skills but not all staff had completed it. The design, maintenance and use of facilities, premises and equipment did not always keep people safe, the areas used for outlier patients were not suitable for this use. Staff did not always keep people safe by following systems and processes when prescribing, administering, recording and storing medicines. The service did not always learn from incidents and accidents as they did not consistently make changes and improvements when they happened.
- Staff gave patients enough food and drink to meet their needs. This service was not seen to be the same service provision for patients using escalation areas. Access to pharmacy support was not available in all escalation areas. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care but there was not always a clear record of how those capacity decisions had been made.
- The service responded reactively to meet the needs of local people and the communities served, which meant care was sometimes delayed. Forward planning to meet demand was not used. Patients could not always access services when needed and not all received treatment in the right speciality ward or area.

Our findings

- Leaders had not yet managed the priorities and issues the service faced. The trust vision and strategy were not known by staff. Staff all expressed that they loved working at the hospital but did not feel supported and valued and often felt isolated within the trust. Governance processes were not effective in developing the service. Learning from the performance of the service was not always maintained or used to make positive changes. The management of risks were reactive and not planned which sometimes left patients at risk.

However:

- Staff understood how to protect patients from abuse. The infection risk were controlled well and kept equipment and the premises visibly clean. Staff managed clinical waste well. Staff completed and updated risk assessments for each patient and removed or minimised risks when possible. Staff identified and quickly acted upon patients at risk of deterioration. Staff kept good care records. Staff collected safety information on each ward and used it to improve the service.
- Managers monitored the effectiveness of some aspects of the service. Staff worked well together using a multidisciplinary approach for the benefit of patients. Key services were available seven days a week. The patients were complementary about the meals and availability of food and drinks. Staff ensured patients had enough to eat and drink and gave them pain relief when they needed it.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff provided emotional support to patients, families and carers.
- The service was inclusive and took account of patients' individual needs and preferences. Staff were focused on the needs of patients receiving care. Staff felt pride in their role and work they undertook. The service promoted equality and diversity in daily work. Engagement was being developed by the trust with staff to improve morale

What we found – Outpatients – Weston

We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink when remaining in the departments for lengthy periods, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.

Our findings

- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

People could not access the service when they needed it and had too long waits for treatment.

Outstanding practice

We found the following outstanding practice:

- In outpatients there was development of a phlebotomy hub in the hospital car park to avoid vulnerable patients entering the hospital. Patients made an appointment with a time slot and waited in their car. Staff took a note of their number plate and returned to collect and escort them to the hub. Bloods were taken and patients were able to leave straight away. This was standard practice for the last year and only stopped when patients no longer had to shield. Patient feedback had been very positive. There were future plans to develop community phlebotomy hubs across the local area.
- As a result of limited face-to-face appointments for dermatology outpatient patients, YouTube videos were provided by clinicians to guide patients to check their skin and lymph nodes. This had proved to be popular with over 127,000 views.

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

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with legal requirements.

1. **Trust wide**

- The trust must seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services and to provide ensure high quality, sustainable care at all locations. To do this, the trust must ensure systems or processes must be established and operated effectively to ensure compliance. (Regulation17 (1), (2), (a), (b), (e), (f).
- The trust must seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. To do this, the trust must ensure people are supported to speak up and raise concerns and that these are listened to and appropriate action taken. The trust must ensure that staff in all areas of the organisation are supported to develop their cultural intelligence and ensure a fully inclusive culture (Regulation17 (2) (e), (f).

Our findings

- All premises and equipment used by the service provider must be properly maintained. (Regulations 15 (1) (e).

Location Level

Action the trust MUST take to improve:

Bristol Medical Care

- The trust must ensure patients in interim beds have access to equipment and have privacy in line with the trust standard operating procedure. For example, access to electrical sockets, call bells and privacy screens. The trust must ensure boarding patients and those in the same bay can be safely accessed should urgent treatment be needed. Regulation 12 Safe care and treatment 12 (2) (d).
- The trust must ensure medical staff receive and complete mandatory training in line with trust targets. Regulation 18 Staffing 18 (2) (a).

Weston General Hospital Medical Care

- Ensure that there are enough numbers of nursing staff, with the right skills to meet patients' needs at all times. Regulation 18 (1) Staffing.
- Ensure nursing and medical staff are supported to maintain mandatory training skills including safeguarding training. Regulation 18 (1) Staffing.
- Ensure there is always adequate cover and support for the medical workforce, including out of hours. To develop and implement an audit in order to provide assurance. Regulation 18 (1) Staffing.
- Ensure the management of consultant behaviours is in accordance with professional standards and that patients are seen by the appropriate consultant within 24 hours of admission. Regulation 18: Staffing.
- Ensure that areas used by patients are suitably risk assessed and have the right environment and equipment to meet patient's needs. This includes the escalation areas, discharge lounge and waterside unit. Regulation 15 (1) Premises and equipment.
- Ensure the management of outlier patients are safe and ensure appropriate medical oversight. Regulation 12 – safe care and treatment.
- Ensure that venous thromboembolism (VTE) risk assessments are completed and recorded according to trust policy and appropriate prescribing of medicines or compression is in place. Regulation 12 – safe care and treatment.
- Substances hazardous to health must be stored securely. Regulation 15 (1) Ensure incidents are investigated without delay and appropriate action and learning is shared to mitigate the risk of reoccurrence. Regulation 17 (1) Good governance.
- Ensure that for patients lacking capacity to make their own decisions a capacity assessment has been completed to provide a clear audit trail of decisions made. Regulation 9 (1) Person centred care.
- Ensure governance systems work effectively to support leaders to make sustainable proactive improvements. Regulation 17 (1) Good Governance.
- Ensure that medical staff attend mandatory training to achieve the trust compliance level. Regulation 18 (2): Staffing.

Weston General Hospital Outpatients

Our findings

- The trust must ensure referral to treatment time performance is in line with national standards. Not all referral to treatment times were meeting national standards (Regulation 9 (1) Person-centred care.

Action the trust SHOULD take to improve:

Trust wide

- The trust should continue to ensure staff are involved in the development of the trust's values of the organisation.
- The trust should consider strategies to improve the representation of staff from black and minority ethnic groups on the board and in senior leadership roles. Continue focus on improving career progression for these groups.

Location Level

Action the trust SHOULD take to improve:

UHBW Bristol main site - Medical Care

- Consider how training can be provided to ensure all nursing staff are supported to complete mandatory training to achieve trust targets.
- Review level three safeguarding adult training and ensure all staff who require this training are identified.
- Review the environment on the endoscopy unit to ensure infection and prevention control standards are met and the premises are suitable for their intended use.
- Consider confidentiality in relation to personal information being on display in ward areas.
- Ensure staff receive regular appraisals.
- Review the need to reinstate a dedicated older person assessment unit which was repurposed due to COVID-19.
- Review effectiveness of wellbeing initiatives to support morale of staff at all levels.
- Review effectiveness of the Freedom to Speak up process to ensure staff are confident to raise concerns.
- Consider ways to improve executive team engagement with staff.

Weston General Hospital Medical Care

- Ensure that checks to ensure patients have the correct medicines (medicines reconciliation) follow national best practice.
- Ensure that patients who may lack mental capacity to make decisions about their medicines are supported to receive medicines in their best interest.
- Ensure that medicines storage areas are only accessible to authorised staff and are within an appropriate temperature range.
- Consider how electronic records could be made less visible when not in use.
- Consider the suitability of moving patients late at night.

Weston General Hospital – Outpatients

Our findings

- The trust should consider how data about medical staffing is collated to be able to easily provide information about the number of medical staff working in the service, the vacancy or turnover rates, sickness rates, and the level of bank and locum staff.

Our rating of well led went down. We rated the trust overall as good because:

- During the core service inspection of medical care at the Weston General Hospital in June 2021, we were significantly concerned about the safe care and treatment of patients receiving medical care. Because of our concerns we imposed urgent conditions upon the trust's registration. The trust was required to take urgent action to protect patients who will or may be exposed to or at risk of harm. We made this decision because the trust had not assured those patients were receiving care and treatment in a ward or department which meet their clinical needs. Also, the trust did not have sufficient medical and nursing staff to meet the needs of patients and there was no effective clinical leadership. These are continued and repeated concerns. We found there were gaps in clinical medical leadership and oversight. Whilst the trust has taken immediate steps to address our concerns, we have yet to be fully assured that the actions taken will be sufficient and sustainable to ensure safe service provision.
- Whilst the board and senior leadership team were aware of the importance of the integration of Weston General Hospital and the wider trust, they recognised more work was needed to further develop this work and to engage with staff to ensure there was a collective and agreed set of values which were not yet in place.
- There were some concerns with culture in the trust and staff being confident about speaking up. There were issues for some members of the black, Asian and minority ethnic staff. For example, we heard from a number of staff who had been told by a line manager to use a westernised name as this would be easier for people to pronounce. Another member of staff was not called by their name in a meeting and no effort was made to learn to pronounce it. Some staff told us they did not always raise concerns as they were not always taken seriously or appropriately supported when they did.
- There were ongoing and unresolved concerns with the support and supervision of a group of trainee doctors based at Weston General Hospital. In both February 2021 and April 2021 Health Education England made the decision, supported by the General Medical Council, to relocate 10 foundation year one trainees (FY1) doctor posts in medicine out of Weston General Hospital. They were moved to Bristol hospitals within the trust, due to the continuation of significant concerns regarding supervision and support for FY1 trainee doctors.
- A number of staff reported they felt no effort had been made to foster good working relationships between staff on the Weston General Hospital and the Bristol sites. However, there had been collaboration and good outcomes in respect of COVID-19 vaccinations for patients and staff.
- There were areas of the trust estates which were in a poor state of repair. However, the trust was working with the estates team to ensure that potentially unsafe areas for both patients and staff were given the priority needed.

However:

- The trust had maintained a safe service during the pandemic. Staff had contributed to decision-making and changes to routines to help avoid pressures from the pandemic compromising the quality of care.
- The senior leadership team told us that they saw themselves as leaders and key partners in the integrated care system of Bristol, North Somerset and South Gloucestershire (BNSSG). They collaborated well with partner organisations to help improve services for patients.
- The trust leaders and teams used systems to manage performance effectively. Teams identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Our findings

- The trust collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were secure and generally well-integrated. Data or notifications were consistently submitted to external organisations as required.
- The organisational priorities were in a 'pause, reflect and recover and reset mode'. We were told by senior leaders this was to ensure there was time to reflect and consider opportunities, identify risks with associated development plans and give sufficient priority and pace. This initiative, which created an opportunity for staff and the organisation to focus on wellbeing during a week focused campaign, aimed to 'reset' ahead of the values engagement work which would then commence.
- The patient experience team was clear the focus at the present time was giving a quality response. However, with the pandemic adding to workload pressures, this had led to some delays in complaints investigation and response times at Weston General Hospital.
- The diligent work undertaken by the infection prevention control teams (IPC) teams, not just in prioritising the risks associated with the pandemic, but also in ensuring that business as usual areas were not impacted. The commitment from this team, their flexibility and resilience and supporting other teams was found to be exemplar.
- There was a committed approach to engagement with patients and communities and learning from their experience and expectations of care.
- The trust was committed to improving services by learning from when things go well in particularly in research and innovation.

Is this organisation well-led?

Our rating of well-led went down. We rated it as good because:

We recognise the dedication and professionalism of everyone working in health and social care and how COVID-19 has been, and continues to be, the biggest challenge to face the health and care system.

Our comprehensive inspections of NHS trust have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level.

We also look at how well a trust manages the governance of its services, in other words how well leaders continually improve the quality of its services and safeguards high standards of care by creating environment for excellence in clinical care to flourish.

We carried out this inspection as we had concerns about the integration of the Weston General Hospital location into the wider University Hospital of Bristol and Weston NHS trust.

The trust had been subject to significant intervention by Health Education England in the removal earlier this year of F1 junior doctors from the Weston General Hospital location.

This summary is focused on the senior and executive management of the trust as well as our core service level assessments of medical care at both Weston General Hospital and the Bristol main site and outpatients' services at Weston General Hospital.

W1 Leadership

Our findings

The leadership was knowledgeable about issues and priorities for the quality and sustainability of services for its Bristol sites. It understood what some of the challenges for the Weston General Hospital location were and had the intention to address them. However, the organisation had not given these sufficient priority to ensure high quality, sustainable care.

Leaders had the skills, knowledge and experience and integrity they need, when appointed and on an ongoing basis. The senior leadership had recently changed with a number of new executive appointments to a large executive team.

There was a process for induction of non-executive directors (NEDs) which was tailored to their individual background and needs. The trust and the NEDs decided how best to spend that time considering whether this was the first non-executive role, or they were already a non-executive in a similar role. There was a focus on building relationships and tailoring accountability and responsibility particularly around any committees they chaired or attended. The NEDs were given access to all the essential documents and information they needed, and key people and teams.

Most trust board governors were elected from members of staff, the public and representatives of stakeholders. There was an active three-year cycle with elections every two years to keep a fluid mix of existing and new governors. The induction programme made it clear about the role of governors in representing their communities.

In terms of the Fit and Proper Person Regulation, the trust policy described how to ensure it was met. The usual employment checks were carried out as required of all directors. Each director would self-declare their fitness every year and the full checks were rerun every three years.

From this and previous inspections undertaken this year at both Weston General Hospital and the main Bristol site we were told by some staff that not all leaders were visible. We were informed by the CEO that senior leaders, during the pandemic, were prioritising safety and were adhering to government and the trust owns infection control procedures. To address some of the staff perceptions in relation to senior leadership engagement the CEO had commenced a weekly pre-recorded broadcast to staff and had increased leadership communications, which we were told had been well received.

Some staff at the well-led inspection told us there was little collaboration to create or understand the vision, values, and expected behaviours for the new organisation, and they did not all know how they fitted into the structure. There was further evidence from our last inspection at Weston General Hospital in March 2021, when we reported staff did not know or understand what the trust's vision, values and strategy were, and their role in achieving them.

The board and senior leadership team were aware of the importance of the integration of Weston General Hospital and the wider trust. Maternity services had undergone an integration in June 2019, 10 months before the trust's merger had occurred. However, the leaders of that program had not been asked to share the lessons they had learnt during that time. A managing director for medicine (Weston General Hospital location) had been appointed from the Bristol medicine team and started in June 2021. This post was created to provide support to the senior clinical leadership to the department of medicine at the Weston General Hospital location and to address the opportunities, integration, risks and sustainability issues at this location. An interim clinical lead for medical education had also been appointed based full-time at Weston General Hospital. The medical director, as did other members of the senior leadership team, told us they felt well supported under the leadership of the chief executive and other members of the senior leadership team and they were sighted on the priorities for ensuring sustainable, effective leadership, which included leadership development programmes, team building and succession planning.

Our findings

Leaders told us they understood the challenges to quality and sustainability and had identified actions needed to address them. The trust reported the process of integrating the clinical services across the Bristol and Weston site post-merger was being accelerated.

Concerns in relation to performance issues in medical care had been raised by external key stake holders during quality surveillance group meetings. Following requests by the trust for additional support, further senior leadership support had been provided from within the local integrated care system. A deputy medical director for NHS England and NHS Improvement southwest region joined the team to support and tackle some of the performance issues in medical care. They would support service transformation as well as engaging with external stakeholders and initiating a stabilisation plan.

At the request of the trust, the ICS had re-established the Healthy Weston Programme Board in April 2021. This was to review the delivery of clinical service development proposals which had been agreed following public consultation in 2019 and to explore further opportunities for developing sustainable models of clinical care in Weston.

Whilst significant challenges existed within the nursing workforce, nurse leadership was felt to be strong, with good support and leadership development in place. Non-medical leadership was also to be strengthened further by the appointment of a head of allied health professionals who would be reporting to the chief nurse. Divisional directors also described support and development to allow them to deliver their roles. However, medical leaders felt they were facing significant challenge, particularly in addressing the challenges brought about by integration, but that they lacked support and development to deliver their role effectively. Several senior staff spoke of the challenge exposed by COVID-19, with staff needing to shield or recover from sickness, leading to a reduction in workforce and an increase in workload. This had exposed an organisation they felt was too “lean.” In other words, the organisation did not have sufficient capacity in bed numbers and staffing levels to perform at the level required and further support was required to particularly support the medical leadership at divisional level to meet those challenges.

The main priorities for the senior leadership team were:

1. Medical recruitment. Applications to work at Weston General Hospital, where there was a high reliance on locum doctors, were low and sometimes zero. This was for all levels of doctors.
2. Capacity. Morale was mostly good, but the challenge was felt to be insufficient bed numbers for general and Intensive care unit (ICU) patients.
3. The blending of the Bristol and Weston location workforces. The process had been delayed by the pandemic and diverse cultures. Actions were being taken to find an equitable solution and senior staff were brought in to support teams at Weston General Hospital.
4. The vacancy rate for the whole organisation was said to be incredibly variable. The biggest concern was the inadequate medical cover for Weston General Hospital which was expected to lead to sickness and stress. With mounting pressures on staff this anxiety was not limited to the Weston General Hospital but also the Bristol sites.

A program of nurse recruitment was underway, including the appointment of a cohort of nurses from overseas. The strategic plan for the medical team included work on recruitment, ongoing work related to capacity, and culture.

In June this year, a new managing director was seconded to work at Weston General Hospital from the Bristol Royal Infirmary. He spoke clearly of the challenges, risks, and opportunities that the Weston General Hospital location had to offer. Although new to this post he was an experienced senior leader and spoke with confidence of the resources, support, and commitment of both the executive team and the organisation. A senior consultant from the Bristol Royal

Our findings

Infirmary was now at Weston General Hospital five-days a week and the clinical director for medicine, also from the Bristol Royal Infirmary, attended one-day a week. The Associate Medical Director for Appraisal and Revalidation was based on site one day per week to assist with any queries and to work on recruitment of medical staff. In addition, the Medical Director was based on site one day per week. A monthly verbal update was provided to the Weston General Hospital senior medical staff by the Medical Director as part of the HMAC Meeting. A clinical chair was in Weston five days per week, a Deputy Medical director five days per week and a Clinical director two days per week. The objective was to further integrate services into the wider trust, and ensure consultants had joint oversight of their service of specialty across the whole trust. All pathways for patients would be unified, in order to provide a consistent approach to processes and standards of work.

As part of the inspection process, we engaged with key stakeholders including Heath Education England (HEE). In January 2021, HEE, through the Southwest Deanery, undertook quality interventions visit. The purpose of the quality interventions visit was to review the education and training environment at Weston General Hospital for foundation year one trainee doctors. The visit sought to follow up on the required actions that were required by HEE from the previous visit in June 2020. Senior leaders at the trust told us they had reviewed the cross-site structure of Post-Graduate Medical Education and agreed a unified, integrated structure across Bristol and Weston, which is now in place. The two legacy structures have been dissolved and there is now an overarching Trust-wide Director of Medical Education (recruited and in post) supported by five Deputy DMEs (recruited and in post) with cross-site educational opportunities in place.

Continued concerns were raised around clinical supervision arrangements for the foundation year one trainee doctors working in the medical division, particularly within the geriatric, medical stroke, and respiratory teams. Whilst HEE found sustained improvements in the supervision and overall experience of GP and foundation trainees in the emergency department, the review team from HEE found significant failures in the provision of educational and clinical supervision in the department of medicine and a lack of patient facing senior supervision, resulting in concerns about both trainee and patient safety. To address feedback from National Health Service England/Improvement (NHSEI) the General Medical Council (GMC) and Health Education England (HEE), the trust added programme management resource to consolidate and coordinate activity into a single detailed workstream action plan. This work continued and the trust was aware this must continue at pace.

A consultation process for pharmacy integration was in progress. However, at the time of inspection pharmacy services in Bristol and Weston locations had different leadership, structures and governance processes.

The lead pharmacist at Weston General Hospital was line managed by the Weston divisional director and did not have a direct route to report Weston specific risks to the trust's medical director. Pharmacy staff at Weston said the trust senior leaders had been open and honest in terms of the executive issues around merging a week into a pandemic. However, the removal of the Weston executive team had led to diminished leadership on site which had been difficult for the staff.

W2 Vision and Strategy

The trust had a vision for what it wanted to achieve and a strategy to turn it into action for the Bristol sites, which had been developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy for Bristol and the surrounding areas. Leaders and staff understood and knew how to apply them and monitor progress. However, the vision, strategy and values of the organisation had not been reviewed and updated to reflect the recent merger of the two trusts.

The vision and strategy for Weston General Hospital was not known by staff. The statement of vision and guiding values for Weston General Hospital was incomplete, out of date, and the trust's overarching strategy was not directly linked to

the vision and values of the whole organisation. The trust had involved clinicians, patients, key stakeholders, and groups from the local community in the development of the strategy approved in 2019 for the then University Hospitals Bristol NHS Foundation Trust. This process involved the North Somerset population served by Weston General Hospital and the Weston Area Health NHS Trust patient council and provided a clear plan to provide high quality care with financial stability. The Transaction Business Case and Post Transaction Implementation Plan that supported the merger between the trusts set out the intention to develop the identity of the new trust and engage staff in agreeing the mission, vision and values in year one as part of the organisational development programme. This plan had been disrupted by the pandemic and the associated need to focus clinical and managerial capacity on responding to operational challenges and maintaining safety. The work to develop new shared values had commenced in April 2021, however this was not as progressive for Weston General Hospital. Whilst work was in progress to develop the values for the new organisation, these were not yet confirmed.

The plans to review and update the vision, strategy and values of the merged organisation in the first-year post-merger (2020/21) as set out in the Transaction Business Case, had been delayed as a result of the pandemic response. A review of the 2025 strategy including the vision, priorities and objectives, was undertaken in 2020 against a number of "new world drivers" which included the integration of Weston and Bristol and extensive engagement with staff to develop the UHBW values was in early-stage *process* at the time of the inspection.

During our inspection of medical care at Weston General Hospital in March 2021, we reported that staff told us they did not know or understand what the trust's vision, values and strategy were or their role in achieving them. This view was held by some staff despite the evidence provided by the trust demonstrating extensive engagement with staff at Weston both pre- and post-merger. Staff told us they felt there was little collaboration to create or understand the vision, values, and strategy for the new organisation, and they did not know how they fitted into the structure. In our well led assessment, and during our core service inspections undertaken in June 2021, staff spoke about the current, although differing, trust's values. It was recognised by the senior leadership team that the values for the organisation were still those which existed before the merger, and they had yet to be renewed for the new trust. However, those leaders and staff we talked with could see how important they were. They said they were powerful when staff did not act in accordance with the trust's values to bring things into focus, and to recognise positive behaviour. Staff were also looking forward learning of the new values for the merged organisation.

It was noted in the people committee board papers for May 2021 that the coming year (2021/22) would see a focus from the trust on embedding an improvement culture across the organisation. This would consider feedback from staff through the assessment of the level of awareness of quality improvement across the trust and would also link with the trust's values work currently underway. The trust risk register had recognised and captured the benefits of transformation, improvement and innovation had yet to be realised. The trust risk register recorded the potential risk that benefits of transformation, improvement and innovation are not realised due to insufficient priority given to developing the trust's culture and the capacity and capability of staff. This potential risk was recognised as mitigated through the Transformation Improvement and Innovation strategy and associated action plan with six-monthly assurance reports provided to the people committee on progress of delivery of the action plan. The trust had recognised the delivery of the action plan within this strategy would mitigate this risk, while the senior leadership were aware of the organisation's priorities following the merger.

Many of the senior leadership team and other senior trust staff recognised the work was not as advanced as would have been hoped largely as a result of the impact of the pandemic and prioritising staff capacity to cope with operational

challenges. At the time of inspection, progress had been made against the merger plans to integrate 21 of 23 corporate functions including the estates and facilities teams and 9 of 32 clinical services. While some senior staff expressed disappointment with the progress and the way in which integration had been managed, others were more positive and said the trust had the skills and resources to make the merger a success.

The Healthier Together Sustainability and Transformation Partnership for Bristol, North Somerset, and South Gloucestershire (BNSSG) brings together 13 organisations from Health and Social Care to work towards creating an integrated care system for the local population by 2021. Executives played a key role in the Integrated Care System, working closely with partner organisations to drive change and development for the region. The trust's strategy "Embracing Change, Proud to Care – our 2025 Strategy", set out the trust's strategic priorities for the next five years. The strategy made references to undertaking an audit against checklist for building improvement capability once the merger had taken place was referenced.

Senior leaders and staff told us they were keen to see progress in system working (as an integrated care system (ICS)) and saw this as positive. They told us they had a great working relationship with the universities and other key stakeholders and saw plenty of opportunities as an organisation to learn and develop.

The medicines optimisation strategies had yet to be aligned following the merger in 2020, but there were some examples of shared priorities. For example, revision of the outsourced outpatient pharmacy service in both locations to ensure contracts were coterminous. Some progress had been made on delivery of the medicine's optimisation strategy. An independent prescribing pharmacist had been appointed within the emergency department at the Bristol Royal Infirmary and a 'flow' pharmacist worked within the medical admissions unit. These appointments had improved the rates of medicines reconciliation prior to admission onto wards and medicines safety, at the Bristol site. Additional funding had allowed for recruitment of medicines management technicians and pharmacists at Weston General Hospital. However, due to other workforce pressures within the pharmacy stores and dispensary at Weston General Hospital, staff were often pulled back from the wards to focus on medicines supply. Development of an electronic prescribing and medicines administration system (ePMA) had stalled in some areas due to its complexities and bespoke models of the system were being utilised.

W3 Culture

Most, but not all staff felt respected, supported and valued. All staff we met were focused on the needs of patients receiving high quality and compassionate care.

The trust told us it promoted equality and diversity in daily work, but this had failed to support a number of staff from multicultural backgrounds and not all felt they were provided with opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear. However, not all staff felt safe or secure about speaking up.

The trust recognised further work was needed to engage with staff to ensure there was collective and agreed set of organisational values and expected behaviours for staff to work to. Work was in its infancy to ensure that staff all levels were engaged, involved, and had ownership of these in relation to their daily roles.

Not all staff felt supported, respected and valued, and staff satisfaction was variable. Improving the culture and staff satisfaction was on the trust's list of priorities as an area for attention and further development. During the inspection

we found teams working in 'silos' and we were told management and clinicians do not always work cohesively. Leaders and staff understand the importance of staff being able to raise concerns without fear of retribution, however, some staff told us that to not always raise concerns as they are not always taken seriously or appropriately supported when they do.

Many staff told us that they were proud to work at trust, and during the inspection, whilst finding some silo working, we also found some strong collaboration and interface working across sites/teams.

Staff described the past 18 months as being pressurised and challenging due to the pandemic, but that individuals, teams, and the organisation were cohesive and committed during this time to provide safe care and treatment for patients in an environment where people were safe at work.

Staff were proud of the work of the trust in leading for Bristol, Somerset, North Somerset and South Gloucestershire (BNSSG) in the national COVID-19 vaccination programme. By April 2021, approximately 30,000 vaccines had been administered across Weston and Bristol.

As an NHS foundation trust, the trust had a Council of Governors whose membership included elected public and staff governors, and governors elected by key stakeholders.

In November 2020, the trust had appointed an external organisation commissioned to undertake an engagement exercise with staff and key stakeholders in respect of the values of the organisation.

The divisional managers felt the wellbeing of staff at the trust, particularly during the pandemic, had been supported and a major priority for the organisation. They spoke highly of the psychological services offered to help staff. Staff also told us of the wellbeing benefits of this support. The pandemic had been overwhelming for many staff including the human resources team (HR). The HR team worked closely together and endeavoured to make the guidance for the wider organisation clear and meaningful, but some staff told us it was overwhelming at times with so many changes.

Staff went out of their way to provide help and support to each other and other teams wherever they could. They helped with moving departments and wards when needed and accommodated/supported patients they were not always used to working with. For example, the children's hospital accommodated young adults in a reconfigured ward to help with pressure on adult services. Also, the intensive care staff from the children's hospital went to support the adult unit when they could. The oncology team were enabled to use the dental hospital. The ophthalmology service and one of the children's teams used part of the Bristol NHS Nightingale Hospital. There was a great deal of innovation and collaboration at this time, although some staff were sad to see most of this now stood down as all services returned to normal ways of working.

However, many staff were feeling the pressure from the pandemic and in some teams or with individuals, the mood was described as low. Staff told us this had contributed to some key staff having left or leaving. It was felt by some staff we spoke with that morale was the lowest it had ever been. There were anxieties around recruitment and retention of staff, and the ownership and ability of the executive team to bring support, raise morale and solve the crisis.

However, for the clinical teams we met, the divisional directors were described as providing strong leadership along with the excellent support from the nursing and allied health professional staff. Staff told us the challenge of the pandemic had been met "incredibly well" by "really passionate and committed clinicians" of all different disciplines. Individual directorates and specialties had been well led with clinical leads enabled to make decisions and changes at the height of the pandemic to cope with the new ways of working.

Our findings

There was a disconnect between management and some clinical staff. This had not been helped by a lack of meaningful clinical and general staff engagement. Many staff who had roles with close links to cultural change, including divisional directors and consultants, reflected there was a lack of staff engagement.

The culture did not allow all colleagues to feel they were treated equitably, and equality and diversity was not always protected in the organisation. Some staff from a black, Asian and minority ethnic background felt the mindset of people they worked with and some patients and families they cared for or supported had not changed despite all the policies and efforts around them. Some felt there remained an imbalance in promotion opportunities and had examples of being overlooked for new roles despite being better qualified than successful candidates. Several staff felt non-white staff were disproportionately disciplined, and they felt more vulnerable to criticism. Some said they felt they had to work twice as hard and have a lot more qualifications just to fit in.

As described by some members of the trust's multicultural staff community, there were concerns around equitable treatment for staff from a Black, Asian and Minority Ethnic background. Diversity and inclusion training was provided, however some staff said were not aware of any training available to them or their managers to help deal with racial abuse by patients or others and practice zero tolerance.

Staff told us about experiencing some forms of micro aggression in their day-to-day working life. Some said responding to these can be taken by other staff as being aggressive. It was said micro aggressions were not well understood by colleagues who are not from a minority background. Nevertheless, many teams can be "brilliant" to work with, but some also can be "very nasty."

We were given several examples of poor experiences for staff which we will not report here to avoid identifying them. However, they were disappointing and showed unhelpful attitudes from across the spectrum of white colleagues and some colleagues from a multicultural background to other colleagues.

Some multicultural staff had noted the use of outdated terms and a proliferation of stereotypes in patient care for those from a non-white background. The concern was this could lead to mismanagement of patient safety and care from stereotypes or incorrect assumptions.

Some staff would report incidents of aggression or racism, but most we spoke with felt this was not done enough. Some staff had felt knocked-back when reporting and made to feel they were the problem. Some staff said they were not afraid to complain if they felt racially abused but equally, they just wanted to get on with their job without this being a part of their lives. They also did not want to relive these things repeatedly.

The staff we spoke with were not aware of any member of trust staff being disciplined around discrimination. There was a lack of diversity in some teams which meant to multicultural staff they were not representative either of the patients and families they were looking after. They felt a wider diversity would help with knowledge and experience of patient care as well as give them more moral support together.

A number of people told us about incidences where members of staff had refused to use someone's name in a meeting as they had not taken the time to find out how to pronounce it. We were also told senior colleagues had changed someone's name to a more western-sounding name as they said they preferred it and had asked staff not to refer to them by their given name.

Our findings

The trust had networks for staff with protected characteristics. The recent appointment of a head of equality was a much-anticipated appointment and there was an expectation that this role and the surrounding support will help to improve standards and awareness this area.

From the trust's perspective, the first bi-annual equality, diversity, and integration (EDI) integrated performance report and the Q1 EDI progress update against the action plan 2021/22 were being reviewed and prepared for governance reporting at the time of this inspection. The report was shared with us and was comprehensive and encompassed all areas of the organisation. It stated the challenges and set-out the strategic action plan for the next year. Progress and exceptions on the action plan would be monitored by the six-weekly EDI steering group, with quarterly updates to the trust's people committee.

Data from the *Workforce Race Equality Standard (*WRES) supported the concerns of multicultural staff. Indicators from the 2020 NHS staff survey showed a statistically significant difference in scores between white and Black, Asian and Minority Ethnic (BME) staff. The results showed 27.9% of BME staff experienced harassment, bullying or abuse from staff in the past year which was significantly higher when compared to 21.7% of white staff. The survey also showed 71.4% of BME staff believed the trust provided equal opportunities for career progression and promotion which was significantly lower when compared to 88.6% of white staff. It was also a concern to note 18.3% of BME staff experienced discrimination from a colleague or manager in the past year which was significantly higher when compared to 5.5% of white staff.

During our core service inspections, and prior to the well led assessment of the trust, we invited staff to complete an anonymous online survey. Staff of all levels and across all sites were invited to take part. There were 1,521 responses. Of these responses, 1,298 responses came from the Bristol site and 221 from Weston. Two responses had an unknown site.

The lowest positive responses centred around senior management and the executive team, including confidence in the executive team, communication from senior managers and senior managers involving staff in decisions.

The survey also showed us that 9.1% of staff reported personally experiencing discrimination at work in the past 12 months from a manager, team leader or other colleagues. At Weston, 14% of staff who responded said they had experienced discrimination.

Staff at Weston General Hospital reported fewer positive responses in all statements in the survey compared to Bristol staff. In 12 out of 17 statements, more than 20% fewer staff at Weston reported positive responses compared to Bristol. The largest difference between Bristol and Weston positive responses was for recommending the organisation as a place to work. Our survey found 74.1% of staff reported they agreed (agreed or strongly agreed) they would recommend the organisation as a place to work while 9.5% disagreed (disagreed or strongly disagreed) with this statement. At Weston General Hospital only 45.7% of staff agreed.

Some staff told us they did not feel listened to. It was noted at a private board meeting in 2021, issues around both clinical and non-clinical staff feeling disconnected were "complex and multifactorial". Factors included the practical element of remote working, the changed working relationships, and fragmented teams. The Board had a concern that staff may be feeling disconnected as a result of the pandemic and remote working arrangements – as a result, in April 2021 the Board invited the Head of Psychology Services and Consultant Clinical Psychologist and Lead Psychologist for staff wellbeing (trust-wide), paediatric palliative care and paediatric oncology services to attend the Board to share the key themes from their interactions with staff to help the Board understand how staff were feeling and how best they could support staff.

Our findings

Some staff mentioned not seeing senior managers on the units and this caused them to feel separate from the rest of the organisation.

There were concerns about equitable treatment for staff at all grades, and particularly for staff at a lower grade. Not all staff felt safe and secure about speaking up. The trust's relationship with those representing the unions and elected staff-side members was said to have been less effective in the last year, whereas it worked well prior to that. This may have been linked to the pandemic, but it had been perceived by some teams that senior decision-making staff seemed unwilling or unable to contribute as they had done before. There was now limited representation of trust senior managers outside of the human resources team at the staff partnership forum and staff representatives felt wider issues were now not always heard.

There was a list of issues brought to the trust by those representing the unions and elected staff-side members which were open for resolution, some of which were said to have been discussed and unresolved for several years. This included inaccurate payments to staff on a lower grade having not been resolved for around two years. There were concerns and perceptions from some staff, from their own experiences, that suspensions took a disproportionate amount of time for lower banded staff as opposed to higher banded staff. We heard staff at a lower-grade, often cleaners and maintenance staff, were quick to be suspended if disciplinary action was commenced, while other more senior staff were moved to other roles and not suspended. Staff believed the suspensions also took a long time to be reviewed for lower-grade staff. This gave mixed messages to staff and made staff at a lower grade feel more threatened in their position and fearful to speak up.

Staff members of the unions had reported not wanting to speak out for fear of losing their jobs. There were staff without substantive contracts who did not feel they had the right or courage to speak out. Staff were said to feel less brave now about speaking out than before and it was felt it was safer to be anonymous when reporting anxieties. There was some concern raised about staff being mocked by other more senior staff if they spoke out.

Within union representation, the staff-side team did not feel they were given the opportunity to engage well in the recruitment process, and not heard when there were issues raised around fairness and equity. We were given several examples of concerns that had been raised but were yet to be addressed around equitable short-listing processes and appointment of candidates.

There were mechanisms for providing staff at every level with the development they needed, including appraisal and development conversations. However, compliance with staff appraisal had dropped considerably during the pandemic, although was a priority for the trust to improve.

NHS England and Improvement issued guidance in March 2020 and January 2021. That guidance specifically advised providers to reduce mandatory training for staff (other than that directly relevant to the COVID response) and to suspend staff appraisals, including medical appraisal.

Staff appraisal was measured as a percentage of staff (excluding consultants) who have had their appraisal signed-off by their manager. The target was 85% trust wide. In April 2021, 6,902 members of staff were compliant out of 10,392 (66.4%). Overall appraisal compliance had increased to 66.4% from 64.9% compared to the previous month. All divisions were non-compliant. To support closing the compliance gap, a simplified form had been developed by the trust which was introduced at the end of May. The work programme to review and align appraisals had been on hold due to the pandemic. However, this had now recommenced. Appraisal training had also restarted in addition to the bitesize videos and guidance available through HR resources to support all managers and staff with appraisal completion.

Our findings

Experience of culture in pharmacy teams was variable among staff groups. There were some significant areas in Weston where some staff felt unsupported and not valued. There was a Freedom to Speak Up advocate within pharmacy at Bristol and Weston. They reported that staff have been speaking up more about concerns in the past year. Feedback was also received through the trust's 'Happy App'. The 'Happy App' is a tool that staff can use to quickly capture their mood and provide more information about what is going right or wrong. Weston pharmacy staff said they received a lot of notifications from the trust in the application about wellbeing, but then did not know where to go or who to speak to about their own wellbeing, despite a wide range of well-being resources available and signposted throughout the trust, for example through COVID-19 updates, posters and weekly staff newsletters.

Pharmacy staff based at the main Bristol site felt there was a caring culture in the trust and leaders appreciated people's efforts. However, they felt the value of pharmacy staff specifically, was not recognised, especially non-ward-based services such as technical services. The trust had sent thank you cards to all staff which included 'seeds of hope' for staff to plant at home. The 'seeds of hope' was described by some as not wanted or necessary, others appreciated this gesture. As with other staff, the rate of pharmacy staff annual appraisal had dropped significantly below the 85% target during 2020 (March 2021 was approximately 57% - which was below the average of the trust overall).

At Weston General Hospital not all pharmacy staff had an annual appraisal and newly qualified pharmacists did not have clinical supervision. Morale at Weston General Hospital was low in the team, and staff felt they were not always delivering a safe service. This had not been identified by pharmacy leaders at Weston. Pharmacy staff did not know who their counterparts were in the different locations of the trust. They reported to us that they felt no effort had been made to foster working relationships between staff on the different sites, although there had been some collaboration around the COVID-19 national vaccination programme.

W4 Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were clear responsibilities, roles and systems of accountability to support good governance and management.

There was a clear performance management reporting structure with monthly governance meetings looking at operational performance at divisional level. Integrated performance reports from divisions were reviewed and then taken up through the internal governance process to the quality outcomes committee. This included a review of incidents reported, complaints, staffing, audit status, infection control, risks identified on the risk register and risk management, and education and training.

During the pandemic, a programme of trust board work was carried on virtually. We were told this broadly worked, but all executive members were said to be keen to get back to face-to-face meetings recognising the value of these.

The board this year were looking at two broad themes:

- Restoration, including digital changes and learning from the pandemic.
- System working where the trust wants to be an anchor organisation for the ICS (Integrated Care System) and 'influencers'.

Our findings

These two themes would flow through the development programme this year and beyond. Although there was a board plan, this was recognised as needing to be fluid to enable it to adapt to meet demands on the NHS and new membership at the board.

Governance and management functioned effectively and interact with each other appropriately. The senior leadership team (SLT) was the executive arm of the organisation. Within this group, senior corporate and organisational executives and managers oversaw the organisational governance and risk. Members of the executive board and divisional directors attended SLT meetings with a formal agenda and the SLT reviewed all reports around risk which went up to the board.

The board assurance framework (BAF) was described as a two-part framework covering strategic risks and corporate objectives. In addition, the board and committees considered the corporate risks every quarter alongside the BAF. Both strands were looked at against the strategy of the organisation and reviewed quarterly at board meetings. The BAF review process would then determine whether further assurances were needed on a certain risk or whether a deep dive into a specific topic should be requested. The BAF was used to provide assurance of delivery of the strategy and aligned with the priorities of the corporate risk register.

Information presented to the quality and outcomes board committee (QOC) was corroborated by the non-executive directors by attending several other committees alongside those they chaired. This included finance and digital, and the audit committee. Non-executive directors told us they had confidence in the papers presented to the quality and outcomes committee. The minutes of this committee were a good reflection of the challenge presented and we were told these had hugely improved over the years. There were action plans following meetings which would always have a due date alongside. These were well monitored.

Safeguarding remained a key priority for the trust and this year's annual report summarised the key safeguarding activities, developments, and achievements in what had been a challenging reporting period. The report provided assurance that the trust was fulfilling its statutory safeguarding duties and responsibilities.

Board level assurance of safety at Weston General Hospital was determined by tracking safety metrics such as falls, serious incidents, pressure ulcers, and staffing levels, which were all retrospective events. We were not assured the process allowed for the mitigation of immediate safety risks and how to manage future known risks. We were told by the new clinical director that the organisation had recognised it was not fully aware of all the risks associated with the Weston General Hospital location, which included the need for clinical review and integration. It was noted in the quality and outcomes committee (QOC) report for March 2021 that a number of processes in relation to the investigation of serious incidents had been delayed including the completion investigations and ensuring actions were closed promptly; this applied across all the Divisions but in particular to the Weston General Hospital division due to the volume of serious incidents being progressed. There were a small number of pre-merger outstanding actions, and it was hoped these would be completed shortly. A new patient safety lead for Weston General Hospital had been appointed and it is anticipated by the trust that this role and surrounding processes and governance would improve the processes around serious incidents management. From data we reviewed it was too early to tell if these interactions were having an impact.

The governance at divisional level was crucial to the quality of data coming to the QOC and data was considered to be of good quality and all useful. The integrated performance report also came through QOC first for scrutiny before going to the trust board. The chair of the QOC would then present this key performance report to the board alongside a written

summary report of key messages. However, we were concerned that board sub committees were held in the same week as the board, and as such, on occasion verbal sub board meeting updates were delivered rather than written papers. If written reports were submitted, the timing of meetings meant there was limited time for board members to read ahead of the board meeting.

There was a strong view by senior staff that notwithstanding the unplanned cancellation of operations in the pandemic and the growing length of time for referral to treatment, the quality of care for patients had been maintained. This was supported by many of the staff we spoke with throughout the trust and was described as happening due to "a superb effort from the staff."

Following concerns, the trust had initiated a standard operating procedure (SOP) designed to ensure routine supervision happened through board and ward rounds on medical wards at Weston General Hospital. Compliance was reported at a quality and surveillance group meeting in May 2021, noting an improvement in consultant attendance, however the associated improvement in the quality of supervision had not yet been seen.

There were effective structures, processes and systems of accountability in pharmacy governance, although some recently improved for Weston General Hospital. Weston general Hospital location was represented at divisional level not at a pharmacy level. There were various medicines governance sub-groups that fed up to the medicines governance group (MGG) or medicines advisory group (MAG), both chaired by the director of pharmacy.

The medicines advisory group (MAG) were responsible for protocols requiring clinician support, National Institute for Clinical Excellence (NICE) approvals, and individual funding requests. The medicines governance group (MGG) was a working group with strong nursing representation looking at aspects of medicines safety, controls, and incidents.

Membership of the MGG included representatives from all divisions including the Weston General Hospital divisional lead. The MGG reported to the patient safety and clinical quality group, chaired by the chief nurse or medical director. There was a pause of these meetings during the pandemic and a new process with gold and silver command was introduced. This coincided with the trust merger and ceasing of Weston General Hospital specific governance groups and was described by a member of the team as a "governance void." Initially there was no pharmacy representation at the Weston General Hospital divisional quality and safety group. However, the lead pharmacist at Weston General Hospital had worked with the lead nurse and medical lead at Weston General Hospital to ensure pharmacy was now represented at a divisional level.

There was a program of internal audits across all divisions which were reported into divisional governance meetings. A safe and secure handling of medicines audit at Weston General Hospital had identified some key themes and an action plan had been drawn up to improve the safety and quality of medicines storage. However, there was limited pharmacy staff to help implement this action plan.

The director of pharmacy for the trust for the Bristol site reported to board on medicines optimisation annually, including key patient safety markers, audit outcomes, progress against strategy. The lead pharmacists for both the Weston General Hospital and Bristol sites reported controlled drug (CD) incidents to the CD local intelligence network and submitted quarterly occurrence reports.

W5 Management of risks, issues, and performance

Our findings

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid operational pressures compromising the quality of care.

There were clear and well embedded arrangements for identifying, recording, and managing risks, issues, performance and mitigating actions in most areas across the trust. From our discussions with senior leaders and staff, a review of the board assurance framework, quality outcomes committee and board meetings, we could see there was an alignment between the recorded risks and what staff told us.

There are arrangements in place for identifying, recording and managing risks, issues and mitigating actions. Staff were able to reports risks within the organisation and anyone could add something to the local risk register. Where this was part of their role, they were involved in monthly meetings looking at risks. Staff said they ensured during governance meetings that divisions were aware of risks within the allied health professional staff group, as these could have potentially detrimental effect on timely patient care and treatment. The patient safety team regularly reviewed the risks and the actions being undertaken to ensure they had been completed. Many staff we spoke with felt the trust had a well embedded and assured risk-management process.

The trust recognised it needed to do more to embed risk management within Weston General Hospital. There were significant risks relating to recruitment, especially at Weston General Hospital. Senior leadership team recognised the issues with the medical workforce at Weston General Hospital did not have an immediate solution, but the team had seen steady, incremental improvement. There were new appointments made and some departments, such as trauma and orthopaedic teams, were a clear success.

There had been a marked deterioration in the performance of the emergency departments. In the year from July 2020 to June 2021, the trust (across all emergency departments) had seen a deterioration in the number of patients seen against the NHS four-hour standard. The standard was to admit, transfer or discharge at least 95% of patients attending the accident and emergency department (A&E).

The average for the year 2020/21 was 80.1% but this had fallen to 73% for the first quarter of 2021/22 and to 70.1% by June 2021. This was reduced to 66.7% when accounting for type 1 emergency patients only. The trust did not report this result against the national average to be able to show a comparison. However, the national average for June 2021 for type 1 emergency patients was 73.2%.

There were also a significant number of patients waiting more than 12 hours on a trolley in the accident and emergency departments. In the emergency department in Bristol this had traditionally not happened in the recent past, but delays caused by a steep rise in demand and a lack of flow of patients (lack of beds) meant this was now a significant factor. At the peak in January 2021, 468 patients waited more than 12 hours on a trolley (12% of 3,825 nationally and the highest in England). By June this had dropped but there were still 146 patients in this category. This was 11% of the number of patients nationally and the second highest in England.

As stated, this performance should be seen among a significant rise in demand for accident and emergency services, as is the national picture. In July 2020, the trust had 12,969 patients attend. In May and June 2021, attendances had risen to 16,523 and 16,871 respectively.

During the medical care inspection undertaken at Weston General Hospital earlier this year, we were concerned that the service did not have enough medical staff at all levels to meet the recommended guidance for the department. There were insufficient numbers of consultants in post and there was also a shortage of junior doctors, with a heavy and

persistent reliance on locum staff. There were only three substantive medical consultants at the Weston General Hospital location when there were posts for 13. The risks to medical and nurse staffing were known and had been included as the highest risk in the merger transaction. Management of the risk and partial mitigation was planned through a recruitment and retention plan at the point of merger alongside on-going operational action to manage rotas. While reports into the organisation and people committee demonstrate continuous actions to seek to recruit medical staffing, we were concerned these actions had not addressed the risks posed to quality and safety also raised by external regulators.

There was also a shortage of registered nurses and heavy reliance on bank and agency staff across many areas of the organisation, but most noticeably at Weston General Hospital. The risks to nurse recruitment have been well recorded nationally, however the trust had been heavily reliant on a workforce in the main from local universities and had only just undertaken an overseas recruitment campaign to address the shortfall. Plans for international recruitment for nurses continued. The trust target date for completion of recruitment of additional staff for the emergency department of the Bristol Royal Infirmary was October 2021.

The trust acknowledged these recruitment challenges put the organisation in a concerning position regarding its ability to provide the required standards of care to patients particularly in the medical care and care of the elderly specialities.

In the organisation, any risk added in the organisation rated through the risk matrix calculation (risk likelihood and severity) as 12 and upwards went to the senior leadership team (SLT) meeting, chaired by the CEO, for review. These risks would have firstly been through the specialty or the division to review before being raised to the SLT. Any risk of 12 or above was allocated a patient safety lead. The senior leadership team would then decide where and by whom in the organisation risks were managed and owned, to ensure appropriate governance, oversight and mitigation were in place.

Operating with limited bed capacity was described as being one of the main risks for the organisation with almost all teams reporting bed shortages. The pandemic had particularly exposed this risk as did the ongoing issues with the timeliness of access to community care packages to facilitate earlier discharges. The increasing number of patients who were fit for discharge but had no onward place to be discharged to was recognised at board level and at system level.

The trust had always had a strong financial position and was felt by members of the finance committee that it remained in a strong position today. Nevertheless, it was recognised plans and budgets were disrupted and skewed by the pandemic for all NHS organisations, and this trust was no different. There was a massive impact on expenditure for items such as medicines, medical devices, and PPE. However, the trust board and finance committee felt in control of the expenditure and that which was centrally funded.

Financial pressures were managed so they did not compromise the quality of care. Service developments and efficiency changes were developed and assessed with input from clinicians so their potential impact on the quality of care was understood. However, we were told by members of the clinical leadership how business cases were slow to process and going through what was described as “layers of bureaucracy.” Important decisions were said to be stuck in endless process and financial governance and there was a recognition that tight finance controls exhibited previously meant areas of the trust estate were in need of considerable investment now.

There were programmes of clinical and internal audit to monitor quality, operational and financial processes and there were systems in place to identify where action should be taken. Board committees had multiple members and there was a clear overlap between committee membership so actions or issues at other meetings could be shared where they had an impact on finance. The finance committee had recently changed in its format to now also incorporate the trust’s digital work. This provided the committee with an even broader range of knowledge and trust insight.

Our findings

The chair of the finance committee felt the work was well balanced, and the level of detail was about right. They were confident about the information provided and its accuracy and integrity. If there were any errors, they were infrequent, but were identified very quickly, were small, and were reported and addressed. This gave reassurance in staff being willing to highlight errors with confidence.

The key role for the non-executive chair of the finance committee was to ensure patient care was safe and finances were available to provide the structure for care to be of a high standard and quality. Assurance of this came also from the other board committee work and the board itself.

The trust was monitoring any safety impact on patients for those receiving treatment They were monitoring the mortality rates at Weston General Hospital which was noted to be within expected parameters and were triangulating this with the Medical Examiner's office. Audits of patients' notes had been undertaken along with a review of significant incidents and review of unexpected escalations of patient to intensive care. All are within anticipated benchmarks and the trust will continue to monitor these.

To work closely with the consultant body at the trust and to also oversee risk, issues and performance, the medical director spent time in wards and departments with clinical teams when on call. He attended board sub-committees and had regular conversations with staff. He described "amazing teamwork" during the pandemic, and this was confirmed by many of the other staff and groups we spoke with. For example, ophthalmology staff retrained to support other specialities and dentists came to support patients and staff. There was support to the emergency department (ED) at the Bristol Royal Infirmary from staff working in multiple specialties.

Executives recognised the response to increased demand was challenging. They were concerned about resilience of the emergency departments (ED) due to the elevated levels of demand currently seen. The reduced and 'too-small' bed-base was limiting and delaying the movement of patients from the ED who needed to be admitted. The intensive care unit (ICU) was also very challenged with patient clinical needs rising due to delays in treatment in the pandemic.

Beds within the Bristol Royal Infirmary were lost as a result of responding to COVID-19 requirements to separate blue and green pathways when the emergency department majors' service was moved into the medical assessment unit, which was relocated elsewhere with less space and therefore less beds. Medical teams were also stretched throughout services.

All aspects of outpatient performance continued to be heavily impacted by COVID-19. Initially capacity was lost at Weston General Hospital due to additional infection prevention and control measures, a shortfall of staff, social distancing and patient choice not to attend. As a result, services did not always meet people's needs. This was recorded on the local service level risk register which clearly identified individual risks and the action taken to mitigate the risks. The position was monitored at monthly meetings within the Weston division.

Outpatient activity had not exceeded pre-COVID-19 levels, except in March 2021. Provisional data for April 2021 showed outpatients at Weston General Hospital were around 90% of April 2019 levels. It was recognised this would not be sufficient activity to manage the follow up backlog demand as well as the ongoing new demand. Capacity was being focused on the delivery of the most clinically urgent cases and was being monitored and recorded on risk registers. There had been significant expansion of telephone or video appointments and 32% of outpatient's appointments were now routinely delivered in this way.

Our findings

From February 2020 to January 2021 the average length of stay for medical elective patients at the trust was 6.4 days, which is lower than the England average of 6.7 days. For medical non-elective patients, the average length of stay was 6.8 days, which is higher than the England average of 5.9 days

From October 2019 to March 2021 the trust's referral to treatment time (RTT) for admitted pathways for showed a deterioration from January 2021 to February 2021, this is in line with most organisations during this time due to the pressures of the pandemic.

From March 2020 to February 2021, the four specialties of rheumatology, thoracic medicine, gastroenterology, and dermatology were above the England average for admitted RTT (percentage within 18 weeks).

Although, the relative risk of re-admission for elective admissions overall were in line with the England average, clinical haematology and gastroenterology had a much higher risk of re-admission compared to the England average

Managers were planning and organising services to meet the needs of the local population and the changing COVID-19 situation. The trust launched an elective restoration programme in April 2021, led by members of the senior leadership team, to coordinate recovery activities based on the core priorities of patient safety, workforce, capacity and capability.

There were arrangements for identifying, recording and managing risks in pharmacy services. The director of pharmacy produced an annual pharmacy performance report that laid out key strategic priorities, key performance indicators and risk. Risks included different pharmacy work practices across the two locations, differing targets and baseline data or unavailability of data for certain metrics from Weston General Hospital.

Both locations had a medicines safety officer (MSO) who investigated and reported on medicines incidents. At Bristol, the MSO had oversight of incident reports from all Bristol locations. The MSO worked with pharmacy and clinical staff at other locations (e.g., St Michael's, the children's hospital, and the eye hospital) to investigate medicines incidents. At Weston, the MSO received all medicines incidents reported solely from Weston General Hospital. They reported to the divisional quality and safety group as needed. Both MSOs were effective at investigating incidents, being involved in root cause analysis and developing learning or process change. They contributed to the independent performance and quality report (IPQR) on medicines incidents causing moderate harm or above.

Not all risks were aligned with what staff said was worrying them. A number of staff told us they were concerned about the estates and the conditions of buildings, along with the reduction in the bed base among rising demand and pressures on the system. Some felt they were required to become even more efficient in getting patients through their care and treatment, when for some specialties they had the lowest length of stay in the country already.

Risks in relation to the estate were recorded on the risk register. There were significant concerns about the condition of the estate. Some areas of the estate were described to us by staff as "embarrassing" with "litter and debris not cleared up effectively." A number of staff at focus groups told us there was inadequate storage in many parts of the premises. Some of the premises had leaks, including raw sewage coming into buildings. Staff raised concerns with us about the safety of some of the estate and sent us photographs showing a corridor with buckets and towels placed to deal with roof leaks in a corridor at St Michael's Hospital. They also said that St Michael's had leaking roofs in gynaecology and staff office areas. Staff also told us of water coming in through the roof in main theatres of the Bristol Royal Infirmary. We were also told the ceiling leaked in the theatre block when it rained.

The risk register showed the trust was aware of its estate backlog maintenance requirements and had targeted its capital investment programme to manage the highest risks within the clinical environment and elsewhere. It had also

looked to invest on additional improvements to the estate targeted on staff wellbeing. The executive team had approved funding for the new Level 9 staff rest areas and support for the temporary extension at Weston General Hospital was confirmed. The Bristol Heart Institute atrium had a temporary staff area that was due to be enhanced. However, it was noted in recent trust board papers that estates had a significant backlog of work which could affect the delivery of the above.

W6 Information management

Leaders and teams collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Appropriate and accurate information was processed, challenged and acted upon. There is an understanding of data by the organisations leaders and teams, and it was used to measure performance. Staff received data which supported them to adjust and improve performance, as necessary, and performance information was used at to hold management and staff to account. The information used in reporting, performance management and delivering quality care was accurate, valid, reliable, timely and relevant, with plans to address any areas of deficit.

Quality and sustainability received sufficient coverage in relevant meetings and staff had access to information to support those conversations. Information technology systems were used to effectively monitor and improve the quality of care. Although work had been done at UHBW (Weston) to improve the quality of discharge medicines and summaries, we were told by medicines management technicians that they do not use their own discharge summaries as a source of medicines reconciliation if people are readmitted, as their accuracy cannot be relied on.

We were informed that the roll-out of an electronic prescribing and medicines administration system (ePMA) had been delayed due to software issues. This had been raised at the trust digital programme board. The intensive care unit, haematology and oncology at Bristol and Weston General Hospital, as well as the Bristol Eye Hospital and outpatients at Bristol Royal Infirmary used electronic prescribing.

There are established arrangements to ensure data and notifications were consistently submitted to external organisations as required. There were arrangements for the availability, integrity and confidentiality of patient identifiable data, records, and data management systems. Information technology systems were used effectively to monitor and improve the quality of care.

The trust was able to provide assurance on information governance breaches reported to the Information Commissioner and through the role of the Caldicott Guardian.

During the pandemic staff recognised the pressures on the information technology (IT) team. Setting up home working for so many staff was said to have caused logistical challenges, however, the IT set-up was said to be run by a strong committed team. The pace of system and process change was said to be “fantastic” and new ways of working had been appreciated. Staff said they got to know so many more people they worked with, and this would remain something which continued in the future.

W7 Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Our findings

People who use services, their views and experiences were gathered and acted on to shape and improve services, this included people in a range of equality groups. The patient experience team were dedicated and well-resourced to provide a patient-focused approach. For example, we were told that caseworkers offered to people the opportunity for people who had cause to complain to speak with them directly, in order to show empathy and an understanding of the concerns and to ensure the voice of the patient was listened to.

The complaints team worked in responding to patients or complainants in a timely manner although this had been impacted by the pandemic and we were aware of a backlog of complaints being dealt with in respect of Weston General Hospital. This was monitored by the board, and recent performance had improved in this area. The priority for the team was the response being fair and what the complainant needed, rather than it being rushed, or not personalised in order to meet key performance indicators in relation to response times. The quality was measured by the very low number of complaints being returned to the trusts complaints team due to them being unsatisfactory to the receiver. The Parliamentary Health Service Ombudsman had also not upheld any complaints in the last year.

Each division of the trust had a complaints coordinator and members of staff from the division were involved in producing the response. Learning from complaints was a key part of the work for the patient experience group. Actions taken for learning were shared with the complainant and they were told they could contact a specific named person at the trust if they wanted assurance the actions had been completed. Actions were shared more widely through the trust in order that learning might help other teams to avoid similar situations. There was a process to ensure any changes made to process or practise had responded to the original complaint and dressed any shortcomings.

People who use services, those close to them and their representatives were actively engaged and involved in decisions to shape services. The patient experienced team were engaging patients in key decisions about the organisation. A focus group had recently been undertaken with sickle cell patients and families in the Afro Caribbean community. This was to address their concerns about healthcare and how it could better support treatment for this illness. There was a growing relationship to the integrated care system and looking at what could be shared to learn from patient experience. This included involving community partners more closely.

In other community work, the patient experience team told us how they had worked with the Sikh community to find out what really mattered to them when coming to hospital. Much was learned from this engagement work. Staff were also being trained to look out for minority groups and check they were given a voice to be heard.

Quality improvement training at the trust had a patient participation angle included. All projects undertaken had to consider patient participation and involvement so patient experience was embedded within the organisation and its change programme. The team was also looking at how to develop the organisational culture around patient participation in areas such as training and development for staff.

Focus groups with patients and communities had been much better attended during the pandemic with the access being through virtual contact. Meetings had continued and flourished with groups such as those speaking for people who were vision impaired or hearing impaired.

There had been a large amount of work looking at virtual visiting for families. Teams in the hospital had tried to be very flexible and address the emerging need to support visitors in a very different way. The patient engagement team had been able to link families together with patients through virtual connections. This had enabled the families to see not just the patient but the staff caring for them and the environment in which they were receiving treatment. Training was still being rolled out to enable staff to manage this system well.

Our findings

The trust was in the initial stages with the patient engagement team of developing 'digital inclusion volunteers' to buddy up with someone to make them feel more confident with technology which had been identified as a need following the greater move to remote consultations brought about by the pandemic.

The volunteers who supported the trust had been a valuable resource for many years. The strategy was now being redeveloped after the pandemic and thinking differently about the future. Some of the actions from a survey of volunteers had included developing a role for mentors for volunteers, and the development of young people as volunteers. The pandemic had hit this group of people hard, with a lot needing to shield and having anxieties about attending hospital sites. However, this gave an opportunity to the trust to develop new roles for volunteers and to restart the programme in a different way. The trust was now offering welcome back sessions, looking at bespoke roles for younger people, and psycho-social roles. There was a plan to look at connecting with isolated patients and to bridge the gap between community and acute services. The trust team told us they felt they has a real opportunity to do something innovative.

There was transparency and openness with stakeholders about performance and there are positive and collaborative relationships with external partners. This is in order to build a shared understanding of the challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. The director of pharmacy team for the Bristol sites had developed established links and support networks regionally and nationally. The medicines safety officers (MSO) for both Weston General Hospital and the Bristol sites joined regional and national networks to share and learn from best practice. The medical safety officer for Weston General Hospital had recently presented a poster at the Bristol Patient Safety Conference on the Making Insulin Treatment Safer (MITS) project, which was well received.

UHBW (Bristol) hosts the regional pharmacy procurement specialist post. This provides a vital link and support between NHS contracting/procurement for medicines and providers as part of an NHS England service. This post also supports national and regional medicines shortages with oversight of all secondary care stock holding in the southwest, supporting and coordinating reallocation of medicines if required.

The period of engagement to develop a single cross organisational set of values had recently commenced, though many staff we spoke with were unaware of this piece of work.

W8 Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

There were clear systems and processes for learning, continuous improvement and innovation. There was a strong and well-established learning culture embedded within the trust. There were effective governance around serious incidents, mortality, and mental health, as well as an ability to effectively learn from complaints and patient experience.

The trust had a research and innovation strategy and there were long-standing, well-established relationships with Bristol University and the University of the West of England. Its research and innovation team liaised with the clinical team within the specialties to deliver clinical trials. There were various ways in which leads for research and innovation promoted research activity within the trust. These included a number of trials during the pandemic, including a number of studies which will look at the side effects and immune response given when people received their COVID-19 booster and flu vaccine at the same appointment.

Our findings

The Transformation, Improvement and Innovation Strategy, the three action half-yearly plan updates, along with examples of the Transforming Care quarterly update the Board. The Transformation Annual Report 2019/20 were shared with CQC provided a number of examples of the quality improvement and innovation initiatives at the trust; these included a bright Ideas competition. The trust also has a quality improvement (QI) hub to provide support to staff, and a QI Forum to share improvements and learning. There is also a QI Academy in place for 3 1/2 years provides QI, project management and change management training for all staff. The trust also has learning from the wider system through membership of Association of Groups, Beneficial Changes Network and Shelford Transformation Network.

Also, staff had articles published in the British Medical Journal, published Sep 20 about #TakePhonership, an element of the Trust Customer Care transformation programme.

There were standardised improvement tools and methods, and staff had the skills to use them. The new role of the medical examiner was now the primary focus for learning from deaths at the trust. The role was undertaken at an integrated care system level with around 18 or 19 medical examiners working across the Bristol, North Somerset, South Gloucestershire (BNSSG) NHS organisations. Around 95% of all adult deaths were reviewed by the team and discussed at monthly meetings.

There were system to support improvement and innovation, including systems and processes for evaluating and sharing the results of improvement work. The structured judgement review process had now been standardised across the organisation. This process was introduced to try to standardise the way patient deaths were reviewed and provide a consistent approach to learning. As a result of learning from death, ReSPECT forms had been introduced in all relevant patient care and extended to include being made available by colleagues from primary medical services. ReSPECT forms describe patients' preferences and any clinical recommendations in relation to their care and any advance decisions they have made. They are not legally binding, and can be adapted as circumstances change, but can help medical professionals meet the wishes of patients in their care. All patients were required to have a ReSPECT form on admission.

The trust had appointed mortality leads for each of the three directorates. The team produced a mortality report which went through divisional governance boards and up to the trust's quality and outcomes committee. The board received an annual report on learning from death which was correlated against the information from the medical examiner to validate data.

Learning from deaths, which was recognised as needing to be shared with others, would go back through the governance process and to the regular speciality mortality and morbidity (M&M) meetings. It was recognised the M&M meetings were well-developed in the surgery teams, but needed to be more formalised in medical teams, and this was planned for improvement. The trust was supported at board level by a non-executive director who supported the work on learning from deaths.

The deputy medical directors we spoke with described some of the learning which had come from patient deaths and how they had included families and carers in the process. This had led to learning around what would be more important or equally important for patients and their families and friends, which may be less apparent to hospital staff within clinical priorities.

Other involvement with patient's families was being gathered through the role of the medical examiner, but this had been impacted due to the pandemic, particularly with some of the limitations around family visiting.

The endoscopy units at both the Weston General Hospital and the Bristol Royal infirmary locations have Joint Advisory Group (JAG) accreditation. To gain this accreditation, the units were assessed against several national standards and

continued to monitor their own service provision to ensure compliance. A review of this award was due in April 2021". The JAG accreditation is a voluntary process for services to engage in. JAG accreditation work to an accreditation pathway which involves self-assessment and quality improvement against the standards. To gain this accreditation, the unit was assessed against several national standards and continued to monitor its own service provision to ensure compliance. Staff take time out to work together to resolve problems and to review individual and team objectives. The Southwest regional Pharmacy Workforce Development South (PWDS) were based within the Bristol Royal Infirmary. This team were responsible for pharmacy education, training and development and funded predominantly through service level agreements with Health Education England (HEE) South and Southwest acute provider trusts. The PWDS is commissioned by HEE South to deliver the pre-registration pharmacist programme to Southwest trainees. The PWDS also deliver the NVQ Levels 2 and 3 in pharmacy services and provide a range of post-registration pharmacy accreditations to support professional development and to meet the needs of workforce. The trust was involved in clinical trials and prescribing and administering genomic medicines.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement Nov 2021	Good Nov 2021	Outstanding Nov 2021	Good Nov 2021	Good Nov 2021	Good Nov 2021

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
South Bristol NHS Community Hospital	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
UHBW Bristol Main Site	Requires Improvement ➔➔ Nov 2021	Good ➔➔ Nov 2021	Outstanding ➔➔ Nov 2021	Good ➔➔ Nov 2021	Outstanding ➔➔ Nov 2021	Good ➔ Nov 2021
Weston General Hospital	Inadequate Nov 2021	Requires Improvement Nov 2021	Good Nov 2021	Requires Improvement Nov 2021	Inadequate Nov 2021	Inadequate Nov 2021
Central Health Clinic	Good Dec 2014	Not rated	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
Overall trust	Requires Improvement Nov 2021	Good Nov 2021	Outstanding Nov 2021	Good Nov 2021	Good Nov 2021	Good Nov 2021

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for South Bristol NHS Community Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
Outpatients and diagnostic imaging	Good Dec 2014	Not rated	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
Surgery	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
Overall	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014

Rating for UHBW Bristol Main Site

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ↓ Nov 2021	Good →← Nov 2021	Good →← Nov 2021	Good →← Nov 2021	Good →← Nov 2021	Good →← Nov 2021
Services for children & young people	Good Aug 2019	Outstanding Aug 2019	Good Aug 2019	Good Aug 2019	Outstanding Aug 2019	Outstanding Aug 2019
Critical care	Good Dec 2014	Good Dec 2014	Good Dec 2014	Requires improvement Dec 2014	Good Dec 2014	Good Dec 2014
End of life care	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
Outpatients and diagnostic imaging	Good Mar 2017	Not rated	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Surgery	Good Aug 2019	Good Aug 2019	Outstanding Aug 2019	Outstanding Aug 2019	Outstanding Aug 2019	Outstanding Aug 2019
Urgent and emergency services	Requires improvement Mar 2021	Good Aug 2019	Outstanding Aug 2019	Requires improvement Mar 2021	Good Mar 2021	Requires improvement Mar 2021
Maternity	Requires improvement Aug 2019	Good Aug 2019	Good Aug 2019	Good Aug 2019	Good Aug 2019	Good Aug 2019
Overall	Requires Improvement →← Nov 2021	Good →← Nov 2021	Outstanding →← Nov 2021	Good →← Nov 2021	Outstanding →← Nov 2021	Good ↓ Nov 2021

Rating for Weston General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Inadequate Nov 2021	Requires Improvement Nov 2021	Good Nov 2021	Requires Improvement Nov 2021	Inadequate Nov 2021	Inadequate Nov 2021
Outpatients	Good Nov 2021	Good Nov 2021	Good Nov 2021	Requires Improvement Nov 2021	Good Nov 2021	Good Nov 2021
Overall	Inadequate Nov 2021	Requires Improvement Nov 2021	Good Nov 2021	Requires Improvement Nov 2021	Inadequate Nov 2021	Inadequate Nov 2021

Rating for Central Health Clinic

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients and diagnostic imaging	Good Dec 2014	Not rated	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
Overall	Good Dec 2014	Not rated	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014

Weston General Hospital

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Uphill
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Tel: 01179230000
www.uhbw.nhs.uk

Description of this hospital

Weston General Hospital provides urgent and emergency services, medical care, surgery, critical care, maternity, services for children and young people, end of life care and outpatient core services.

On 1 April 2020, University Hospitals Bristol NHS Foundation Trust and Weston Area Health NHS Trust merged to form a new organisation, University Hospitals Bristol and Weston NHS Foundation Trust (UHBW).

Following the merger the previous ratings for Weston General Hospital do not apply.

When a trust acquires or merges with another service or trust in order to improve the quality and safety of care, we will not aggregate ratings from the previously separate services or providers at trust level for up to two years. Therefore, we have rated services at Weston General Hospital as this inspection. However, these ratings do not form part of the Trust's overall current rating.

Our rating of this location is inadequate. This rating is based on the inspection of two core services.

We rated medical care as inadequate overall and outpatient services as good overall:

- The medical care service did not always have enough nursing and medical staff to care for patients and keep them safe. The service provided mandatory training in key skills but not all staff had completed it. The design, maintenance and use of facilities, premises and equipment did not always keep people safe, the areas used for outlier patients were not suitable for this use. Staff did not always keep people safe by following systems and processes when prescribing, administering, recording and storing medicines. The service did not always learn from incidents and accidents as they did not consistently make changes and improvements when they happened.
- Medical care staff gave patients enough food and drink to meet their needs This service was not seen to be the same service provision for patients using escalation areas. Access to pharmacy support was not available in all escalation areas. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care but there was not always a clear record of how those capacity decisions had been made.
- Medical care staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff provided emotional support to patients, families and carers.

Our findings

- The medical care service responded reactively to meet the needs of local people and the communities served, which meant care was sometimes delayed. Forward planning to meet demand was not used. Patients could not always access services when needed and not all received treatment in the right speciality ward or area.
- Medical care leaders had not yet managed the priorities and issues the service faced. The trust vision and strategy were not known by staff. Staff all expressed that they loved working at the hospital but did not feel supported and valued and often felt isolated within the trust. Governance processes were not effective in developing the service. Learning from the performance of the service was not always maintained or used to make positive changes. The management of risks were reactive and not planned which sometimes left patients at risk.
- People could not access the outpatient service when they needed it and had too long waits for treatment.

However:

- The outpatient service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Outpatient staff provided good care and treatment, gave patients enough to eat and drink when remaining in the departments for lengthy periods, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Outpatient staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The outpatient service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Outpatient leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.
- Medical care staff understood how to protect patients from abuse. The infection risk were controlled well and kept equipment and the premises visibly clean. Staff managed clinical waste well. Staff completed and updated risk assessments for each patient and removed or minimised risks when possible. Staff identified and quickly acted upon patients at risk of deterioration. Staff kept good care records. Staff collected safety information on each ward and used it to improve the service.
- Medical care managers monitored the effectiveness of some aspects of the service. Staff worked well together using a multidisciplinary approach for the benefit of patients. Key services were available seven days a week. The patients were complementary about the meals and availability of food and drinks. Staff ensured patients had enough to eat and drink and gave them pain relief when they needed it.

Our findings

- The medical care service was inclusive and took account of patients' individual needs and preferences. Staff were focused on the needs of patients receiving care. Staff felt pride in their role and work they undertook. The service promoted equality and diversity in daily work. Engagement was being developed by the trust with staff to improve morale.

Medical care (including older people's care)

Inadequate

Is the service safe?

Inadequate

This was the first comprehensive inspection of this service.

We rated it as inadequate.

Mandatory Training

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

Nursing staff had not received and kept up to date with their mandatory training.

The trust had set a compliance level of 90% for mandatory training, this had not been achieved in all areas of training. Overall mandatory training compliance for Weston Hospital medicine division was 89%. At this inspection we found that training levels for nursing staff varied with shortfalls seen in moving and handling, patient safety, resuscitation and safeguarding to level three. We did not see any impact on patients caused by the reduced training levels.

Training was provided virtually for all mandatory areas except basic life support, which was a practical face-to-face training session. Staff completed training outside of working hours but were paid for their time. Staff told us they received specific training when needed to provide non-invasive ventilation, management of sepsis and how to provide dementia care.

Medical staff had not kept up to date with their mandatory training.

The trust had set a compliance level of 90% for mandatory training, for medical staff this had not been achieved in most areas. Overall mandatory training compliance for Weston Hospital medical staff was 66%. Medical staff told us that time was being made to support their ongoing training. We were told that locum staff do not access the same level of training.

The mandatory training was comprehensive and the content met the needs of patients and staff.

Staff told us the quality and content of the training was appropriate and relevant to their needs. Training compliance was recorded and monitored through an electronic staff record. Staff confirmed that they were alerted by email when training was due. They told us that some delays in training were caused by staff shortage but catch up training was being provided.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it. Some staff were not up to date with this training.

Nursing staff we spoke with told us they had completed safeguarding training for adults and children, and the level of training varied with their role.

Medical care (including older people's care)

The trust risk register identified as a high risk that staff were non-compliant with level three safeguarding training. However, there were no actions listed to mitigate the risks posed to patients if staff did not have up to date training. Staff told us that staffing levels sometimes had meant that they could not attend planned training. Nursing staff training records identified that 64% of nursing staff had attended safeguarding adults' level three training.

Medical staff had access to safeguarding training which they confirmed they had attended when able. The trusts training records identified that 67% of staff had completed safeguarding adults' level two training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff demonstrated an understanding of anti-discrimination and provided person-centred care. For patients with mental health problems staff would consider patient support and safety as part of their risk assessments and provide the appropriate care when possible.

Staff knew how to identify adults at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff understood the different forms of abuse and what action to take to promote patient safety. Staff explained the training enabled them to identify potential safeguarding issues and could get access to further safeguarding support and advice if needed. Staff were confident to report safeguarding concerns to ensure the patient's safety.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff used electronic systems to alert safeguarding risks to the safeguarding team and the local authority.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were visibly clean and had suitable furnishings which were well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

The safe storage of chemicals was not seen on some wards. Chlorine tablets were accessible in some areas which if ingested would be hazardous to health. We informed staff at inspection who removed them immediately.

Housekeeping staff were allocated to wards we visited, and we saw good levels of cleanliness and hygiene. Housekeeping staff told us they enjoyed their role and felt supported. They were made aware of any risks of cross infection and they had access to personal protective equipment.

The service used monitoring tools to ensure good standards of cleanliness were maintained. We saw cleaning schedules on wards which had been completed, signed and dated. Each ward completed audits and displayed scores at the ward entrance. We saw on wards we visited scored between 97% and 100% for hygiene levels. Hand hygiene audits were displayed on all the wards and departments we visited and results for most areas were good, with most being 100% compliant.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff followed infection control procedures. Staff were arms bare below the elbow, in line with trust policy. Staff used personal protective equipment, such as gloves and aprons, when required, and disposed of these correctly in clinical waste bags. We observed doctors and nursing staff washing their hands and using anti-bacterial gel in line with trust policy. Single rooms were used for patients with potential or confirmed infections, to reduce any risks of cross infection. These rooms were clearly signed with appropriate personal protective equipment available to staff and visitors before entering.

Wards had various prompts to remind everyone to consider infection risks. On Sandford ward patients' visitors were issued with a letter, which informed them of their responsibilities around infection control. On Uphill (the stroke ward) a bell sounded hourly to prompt nursing staff to clean around them.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Staff cleaned equipment after each patient contact and labelled equipment to show when it was last cleaned. The endoscopy unit used established cleaning protocols on scopes and equipment.

Staff disposed of clinical waste safely.

Single use items of equipment were disposed of appropriately, either in clinical waste bins or sharps instrument containers. We saw that sharps disposal bins were closed when not in use.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. However, there was an issue with the emergency call system in the discharge lounge.

A recent incident in the discharge lounge highlighted the need for clear procedures in an emergency. A patient needed urgent medical attention, the emergency bell was used and found that it only sounded in the discharge lounge and immediate surrounding area. The procedures for getting further urgent assistance needed a call to be put out via switchboard. Due to a lack of call bell sound to surrounding areas, the risk would be that nearby services would not be alerted to come and provide immediate assistance

The trusts risk register noted as a moderate risk that patient safety was compromised if the emergency bell was not audible, resulting in a delay to emergency treatment. The risk register item did not refer to the discharge lounge and the mitigating actions noted in the risk register did not reference how this would be managed at this location.

We observed that staff responded promptly to general call bells. We saw that staff were allocated to bays and remained in those bays to support patients as needed.

The design of the environment did not follow all national guidance.

Not all areas were safe for patients suffering from mental health crisis. We saw on the Medical Assessment Unit (MAU) and Kewstoke ward there were ligature risks in toilets, which we were not able to confirm if they had been risk assessed to promote patient safety. Staff told us this risk would need to be assessed for all patients and would require extra monitoring to ensure patients at risk of self-harm were safe.

Medical care (including older people's care)

Staff mostly carried out daily safety checks of specialist equipment.

Emergency equipment was mostly checked daily in accordance with trust policy. Equipment for urgent and emergency situations was kept in tamper-evident trolleys and was mostly checked daily by staff. Records of these checks were signed and dated. We saw two trolleys on the Medical Assessment Unit (MAU) and Sandford ward which had some gaps in checks. This meant there was a potential risk items needed in an emergency may not be available.

The service did not always have suitable equipment to help them to safely care for patients.

Escalation areas used at times of high operational pressure were not always suitable and safe for patients and staff.

The use of escalation spaces on the surgical day case unit, the Waterside unit and the Geriatric Emergency Medicine (GEM) were not always used within the standard operating policy completed by the trust. The environmental risk assessments identified by the trust as being needed for each patient, were not consistently used and so did not always ensure the safety of patients admitted there.

Surgical day case unit

The surgical day case unit was not a suitable or safe place for medical patients. The unit ran as a day case facility opening at 8am and closing at 5pm. The unit had a standard operating procedure (SOP) for patients to remain overnight if necessary. This SOP was for surgical patients and did not include the details needed for medical patients to remain overnight. On 08/06/2021 at midday we visited the surgical day case unit where four medical outlier patients had been admitted overnight and were awaiting medical review. 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.

There was an identified risk that the surgical day case unit did not have the appropriate facilities for use by outlying patients. The trust risk register included that using the surgical day case unit as an inpatient area could lead to patient harm. Risks were identified and rated. However, no action plans were provided to ensure that appropriate actions were considered, and no ongoing reviews was used to monitor patient's safety.

The facilities within the unit were not suitable. The unit had one toilet and sink and had no showering facilities. There were enough sinks and handwash facilities for staff. The unit had access to oxygen at two of its five beds and so should a patient deteriorate or require oxygen, bed moves may be needed. there was inadequate lighting available for inpatients overnight and there were no lockers to store personal items.

The unit also did not have pharmacy support or available medicine stocks. This meant that where patients arrived without medicines, there could be delays in accessing medicines. See the medicines section of this report.

Waterside Unit

The Waterside unit was a small unit separate from the main ward areas. It had been used originally as a surgical ward for private patients. All rooms were single rooms off a central corridor. The private unit had been used by the trust during the COVID-19 pandemic and now provided a three bedded "Blue area" for patients admitted with COVID-19 identified symptoms. The remaining beds were being used at an admissions ward, taking patients from the emergency department with a maximum anticipated length of stay of 72 hours. All beds were in single rooms.

Medical care (including older people's care)

The use of the Waterside Unit for medical patients was not safely managed. The Waterside Unit had not been assessed or identified as a suitable place for medical patients, however it was being used for this purpose.

There was no standard operating procedure or guidelines to identify and guide staff regarding the appropriate and safe use of this unit. As a result, patients with varying level of severe illness were admitted. Staff confirmed that patients admitted included those requiring cardiac monitoring and non-invasive ventilation.

The risks to patients of using the Waterside unit were identified in the trust risk register and included a risk that a lack of respiratory staff available to care for patients needing ventilation support (high risk identified 06/11/2020), that anti ligature points were not fitted on the unit (high risk 09/10/2018). The register also noted that patients couldn't be moved safely due to mobile hoist faults (10/12/2019 high risk), that high levels of agency staff were used (10/01/2019 high risk) and that a lack of essential monitoring equipment and skilled staff to care for acutely ill patients may lead to harm (02/11/2020- moderate risk). The register also noted the risk that patients could not be observed due to no viewing window in patient doors (03/10/2020- moderate risk) and no medicines reconciliation was available so risks of incorrect medicines being given and a risk due to inadequate staffing (04/04/2020 – moderate risk).

The doors into each side room needing glass to enable nurses to see the patients had been formally identified as a risk following an incident. The trust risk record noted this as a moderate risk because patients could not be observed due to no viewing window in patient doors. In January 2021, the register noted a request to adapt doors to include a window or remove doors and add clear curtains, however, at the time of our inspection this had not been completed.

The unit was staffed by four nursing staff which meant that because of the lack of visibility, patients went for periods of time unobserved and at risk.

Geriatric Emergency Medicine unit

The geriatric assessment unit was a three bedded unit close to the medical assessment unit. Its original use was a frailty unit to enable frail patients to be reviewed and assessed with a view to potential admission to the hospital. There were no allocated permanent nursing staff with medical and nursing staff being mostly provided from the medical assessment unit. There were no toilets or showers available and therefore these had to be accessed outside the unit when required.

The use of the Geriatric Emergency Medicine (GEM) unit for medical and surgical admissions when the hospital needed more beds for patients, was not safely managed. There were no risk assessments by the trust for the use of this environment as an escalation area and no planning for staffing levels for this unit when in this use.

The SOP for this area stated that patients admitted to the GEM unit ideally should be reviewed by the nurse in charge of the medical assessment unit prior to transfer, to ensure they met the identified criteria. However, three staff described incidents when this assessment had not been completed and admission had not been agreed with the nurse in charge of the MAU. Patients had been admitted to the GEMS unit outside of the criteria specified.

The SOP identified patients should be low risk, ambulant, self-caring, not monitored and medically stable. On both days of our inspection, we found there were patients who did not meet the SOP criteria for admission.

Following our inspection, CQC took enforcement action against the trust and as a result these three areas were closed to use as escalation areas.

Medical care (including older people's care)

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. Staff identified and quickly acted upon patients at risk of deterioration. Risk assessments for outlier patients did not ensure their safety.

At our previous inspection in January 2021, we saw there were sometimes delays in recognising deteriorating patients and that escalation to medical staff was not always timely. Audits of the tools used to recognise deterioration, were not used to improve practice. At this inspection, we saw that the issue had improved, and the charts viewed had been accurately completed and we saw records of prompt and appropriate action taken.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.

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 five patient NEWS charts we reviewed were completed and acted upon as needed.

Staff demonstrated the handheld device used to gather the patient observation information and how this prompted action if the scoring identified a risk.

Staff completed risk assessments for each patient on admission and reviewed this regularly, including after any incident.

Staff completed risk assessments for each patient on admission or arrival onto the ward, using a booklet which contained the risk assessment templates. 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. A delay in recognising concerns had the potential to cause harm to patients. We looked at records and saw that there were very few cases when the assessments as part of patient admission had not yet been fully completed in a timely way.

Staff completed audits monthly to ensure the NEWS were being completed correctly and to ensure patient safety.

Staff knew about and dealt with any specific risk issues.

Once patient risks were identified, care plans were developed to inform staff of the individual care and treatment the patient needed. We found that staff reviewed the risk assessments and associated care plans regularly, including after any incident such as a fall or deterioration or change in health needs. However, we also noted that venous thromboembolism assessments had not been consistently completed and reviewed. This created a risk for patients who were then given anticoagulant medicine.

Work was being undertaken by the falls lead nurse, looking at how to reduce the risk of patient falls. Patients at high risk of falls have a member of staff in the bays with them and the trust refer to this system as using tag bays. A tag bay is a specified area where before a member of staff cannot leave without a replacement to take over from them. We saw this in practise during our inspection.

There was a falls lead nurse for Weston Hospital, and they had audited the number of falls at Weston Hospital. The data was for the whole hospital and was not specific to the medicine directorate. They explained that the trust set target for falls per 1000 days was 4.8, the trust achieved below that at 3.10 days and had not seen an increase during the COVID-19 pandemic.

The trust recognised the risks of skin pressure damage and we saw data which may identify a high reporting level of tissue viability incidents. We saw that tissue viability specialist staff supported the wards. We did not see any data which indicated an increased risk of hospital acquired pressure damage and viewed a record of one patient who had a hospital acquired pressure sore and saw that learning and appropriate action had been taken.

Shift changes and handovers included necessary key information to help keep patients safe.

At our previous inspection in January 2021, we saw that the management of laboratory results had the potential to create delays in the right doctor receiving and reviewing the results. At this inspection, we saw that this issue appeared mostly to be resolved. Staff demonstrated using the computer systems to show that laboratory results were now allocated to the patients record and requesting doctor. The trust standard operating procedure for 'interim ward cover on medical base wards and outlier wards' (professional standards) stated that when a patient moved between wards, and therefore to another consultant, the named consultant would also be changed on the computer system to ensure all laboratory test were returned to the correct consultant. An audit was planned to ensure that the system was effective, however at the time of inspection the trust did not have assurance of the systems success.

Staffing

Nurse staffing

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

At our previous inspection in January 2021, we saw that 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. At this inspection we saw that while there were still not enough nursing staff numbers, there were sufficient therapy staff.

Managers calculated the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance but did not ensure that staffing met that level.

At our previous inspection we found there was a chronic staffing shortage which resulted in delays for patient care and poor staff morale. At this inspection there remained high vacancy rates on the wards with over 100 nurse vacancies identified and gaps in rotas covered by agency and bank staff. When bank or agency staff were not available, the shifts remained uncovered.

The trust had an action plan to address staff shortages. However, the actions had not progressed enough to ensure staffing levels were safe. The bed occupancy level at the hospital was 100% and that meant that staffing levels should have exceed the existing full staffing requirements, but these levels had not been met.

The trust risk register noted that there was a high risk that nurse staffing would not be at the required numbers. The actions identified to mitigate the risks were not seen to be successful on the wards. A plan to recruit had been developed. However, staff had not felt the benefit of any increase in staffing levels.

The risk trust register noted as a low risk that patients could come to harm due to inadequate staffing. Staff told us that the impact on patients was minimal because they worked hard to ensure patients' needs were met and that they felt cared for. Staff told us that the impact of that extra workload was seen in staff morale. Staff felt that reduction and retention of staff had not been addressed.

Medical care (including older people's care)

The service did not have enough nursing and support staff to keep patients safe.

A safer staffing tool was used to review levels of patient need and associated staffing requirements. The numbers of planned and actual staff on duty was displayed at the entrance to each ward. Most wards we visited during our inspection did not have the right number staff on duty, as planned for. This meant that the nursing levels were not as they needed to be, and staff were spread wider across the wards.

Staff we asked, without exception, told us they were exhausted with working short of the identified staffing levels. We saw on the medical assessment unit, Sandford ward, Kewstoke ward, Harptree ward and Berrow ward that the calculated and planned staffing levels were not covered by staff. Staff confirmed they frequently worked with less numbers of trained staff than agreed.

We saw examples of shifts not covered. On day one of our inspection at 4pm, Kewstoke and Berrow wards had shifts for that night not yet covered and on day two of our inspection, the surgical day case unit (used as an escalation area for medical patients) and three other wards had vacancies for nursing staff not yet covered.

Staff described the management of staffing as reactive, not proactive. We saw staff being asked to move from wards to escalation areas and other areas that were short of staff. The forward planning to staff areas to their planned level and to anticipate increased need to cover escalation areas was not effective to ensure sufficient staffing at all times. At this inspection, we found the hospital at full capacity with delays in discharges. We saw that the predicted admissions of patients through the emergency department would need escalation areas to be opened to meet the demand for admission bed. However, these areas were not staffed in advance, which meant that staff were always being pulled from other areas and this put them under pressure and patients at risk. Senior ward staff explained that when bank and agency staff were not available, they had no other option than to work with less staff.

The trust used a ratio of patient to staff as a guideline for staffing levels. This had been explained to staff as one registered nurse to six patients each day and one registered nurse to eight patients at night. This system did not consider fluctuating levels of patient acuity or surges of demand and so required staff to be sourced at relatively short notice.

We saw when staffing levels had not been met. On Friday 4th June 2021 we observed on Sandford ward that there was a trained nurse in charge and one other agency trained nurse and four health care assistant staff. This meant that the trusts standards of one registered nurse to eight patients overnight would not be met and staff would have more than eight patients each to care for. We saw another example on the same ward on Friday 4th June, when one registered nurse had nine patients to look after and six discharges. This increased workload also did not consider the acuity of the patient’s needs.

The Waterside unit was staffed mostly by nurses from other areas or by agency staff. The safer staffing tool was used to identify staffing levels, but staff confirmed this tool did not consider the acuity of patients transferred from the emergency department or the lack of visibility caused by the single room design. There was no visual access to monitors or equipment outside of the rooms. This meant patients with non-invasive ventilation or cardiac monitors would need enhanced nursing supervision, this would need an increase in staffing but was not available.

Staff told us the management of GEMS was usually chaotic with staff diverted from an already short-staffed MAU or another ward. The unit was required to be staffed by a registered nurse who was usually from the medical assessment unit or agency staffed. During our inspection we found on more than one occasion that there were no staff present on the GEM. We raised this with MAU nurse in charge who explained that there were no staff available to cover when staff allocated were on breaks. A health care assistant was to be allocated as an interim measure.

The matron of the day could adjust staffing levels according to the needs of patients.

Staff explained the system for requesting bank and agency staff was not effective. Safer staffing meetings were held at 08:15 each day and then reviewed as part of bed management meetings throughout the day. Matrons, other senior nursing staff and site coordinators attended, to discuss staffing resource and patient acuity. Ward staff requested staff for the next 24 hours at the 08:15 staffing meeting. The matron of the day would then attempt to fill the posts with bank staff in the first instance. If this was not possible, they would make a request to the head of nursing to request agency staff. This may or may not be agreed. Staff were not informed if the shortages of staff were addressed or unable to be filled and would arrive to work to find they were short of the planned staffing number.

We were told of an example on 07/07/2021, when those requests were made to the matron of the day at 08:15 for trained nurse cover for the following day. However, by 4pm no cover had been provided. Therefore, on the day, the ward which had a planned registered nurse staffing number of four, had only two registered nurses. Other staff had to be found from elsewhere to staff the ward.

There was an additional pressure created by staff being counted within the ward complement when they had not yet developed enough skills to work independently. These included staff on induction or newly qualified nurses, so while the numbers of staff appeared almost suitable; the skill mix was not correct and was a further pressure of responsibility for the existing, experienced staff.

Therapy staff were accessible on wards. The stroke unit had its own physiotherapist and occupational therapists and these staff were not shared across the medical division. This enabled a concentration on rehabilitation for stroke patients. Speech and language therapists were available by referral. To mitigate for the times the speech and language therapists were not available, ward staff had completed the training to undertake swallow assessments. This meant patients did not have to wait without liquids and food for a referral to be activated.

Medical staffing

The service did not have enough medical staff to provide the right care and treatment.

The service did not have enough medical staff to keep patients safe. The service had increasing vacancy rates for medical staff. The medical staff available did not match the planned number.

At our previous inspection in January 2021, the service did not have enough medical staff to meet the recommended guidance. There were insufficient numbers of consultants in post. There was also a shortage of middle grade doctors. At this inspection, we saw that this remained the case with three consultants in substantive posts and the remaining consultants being locum doctors. There also remained a shortage of middle grade doctors.

The consultant rotas showed that from January 2021 to the date of this inspection, there were 12 consultant posts across the medicine directorate. Of those three were filled with permanent staff, one had not started yet, and one was leaving in July 2021. There were a further two vacant posts not yet filled. The remaining posts had been filled with locum

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

The trusts risk register noted as a very high risk that the numbers of available consultants were insufficient to fill the on-call rota. During out of hours (21:00-08:00) there was a consultant physician on call every night. They were always contactable by phone and could attend site if required. At weekends there was a consultant physician on site between 08:00-21:00. We reviewed the medical staff on call rota for consultants from January to June 2021 and saw that while one consultant on call cover had been found for each day, a second on call consultant post had not been filled on most occasions.

There were not enough registrar level doctors working in the medical division to cover areas of the staff rota. We were told the registrars continued to manage patient outliers and so were not always accessible or available, and there were times when one registrar would be required to cover more than one ward or area. We reviewed the registrar doctor level rota and saw gaps where shifts had not been covered. We saw that there were 11 registrars in total with five vacancies. Of the 11 registrars, eight were included in the on-call rota. That meant a significant on call responsibility for the eight registrars. The registrar rota also showed gaps in cover. For example, from December 2020 to March 2021 shifts not covered were noted each month totalling 27.

The service had high rates of bank and locum staff

We reviewed the core medical training or Senior House Officer doctor level staff duty rota. There were 22 in total, with four being locum staff and one being a bank employee. The rotas showed that as of 16 June 2021, the on-call rota had gaps of 9 days to cover for July 2021 and 18 days to cover for August 2021. There were gaps for core medical training doctors from August 2020 to March 2021, totalling 60 shifts.

The medical staff booking records showed that from April 2020 to March 2021 48% of all shifts were bank staff and 40% were agency staff. The record noted that 720 shifts were presumed unfilled.

The service did not always have a consultant on call during evenings and weekends.

There were also areas of consultant workload and behaviours which required continued management to ensure patient safety. The trust leadership team had previously 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 to improve how they worked on the wards, and ensure their behaviours were in accordance with professional standards. Action taken so far had not been effective. For example, 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”. The aim was that a named consultant physician was identified 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 was achieved mid-week. However, no consultant attended the wards at the weekend, with on call consultants noted to be available by telephone if needed.

We also saw that behaviours were not in accordance with professional standards. The SOP identified that new patient admissions would be seen by a consultant within 24 hours of arrival to the ward. This was not yet successful. This aspect of the SOP continued to not be consistently managed, as consultants were not available on the wards, including the medical assessment unit at the weekends. The leadership team were planning to audit compliance with the SOP and manage underperformance, but no audit outcomes had yet been available.

A further project had been started by the management team, looking at board rounds and how they were managed and the level of consultant attendance. This included the timing of ward rounds and how this impacted on the service, for example delayed ward rounds impacting on delayed discharges. Staff told us that currently only the stroke ward completed ward rounds early enough to facilitate discharges before lunchtime.

The management of patients in the surgical day case unit was not in line with the trust standard operating procedure. The SOP stated that all patients transferred to this unit must have an identified consultant and contact numbers for the appropriate on call doctor documented in the patients notes. However, we found that staff were not made aware of the patient's consultant or responsible doctor. The staff had not been informed who was medically responsible for each of the outlier patients, they did not know who would be reviewing them or when that would be. They told us they would have to telephone around the medical team to find which doctor had been allocated these patients. They confirmed this frequently happened. If the patients deteriorated, they told us would call the on-call site medical team or the emergency response team. The trust's risk register noted if a patient's responsible consultant could not be easily identified, that was a high risk.

Medical staffing on the Waterside unit was variable and did not have a regular consultant presence. The unit had a consultant led round Monday to Friday with the weekend round being completed by the on-call registrar. The Waterside unit was staffed daily by two senior house officer level doctors and by the out of hours medical on call team overnight. There was no registrar allocated to the area, if support was needed the medical staff could contact the medical registrar on duty. A consultant was allocated to the area but this changed each week so there was no consistency of support or practice.

Records

Staff kept detailed records of patient's care and treatment. Records were clear and most but not all, were completed and updated. Records were mostly stored securely and easily available to staff providing care.

At our previous inspection in January 2021, we saw that while comprehensive risk assessments were mostly being completed for patients that needed them; staffing shortages created a risk that deteriorating patients were not always recognised in a timely way. At this inspection, we saw that most records were well completed but some risk assessments had not been completed.

Patient notes were comprehensive, and staff could access them easily.

Patients' records demonstrated a multidisciplinary approach with assessments and care plans from the medical team, nursing team and allied health care professionals. There were paper observational records stored with the patient by their beds to enable a continuous record to be easily available to nursing and medical staff.

Medical care (including older people's care)

Paper booklets were used for the patient's initial assessments and for their inpatient stay. These included care plans. These documents were generic templates which staff were required to complete. We looked at 13 sets of records and found that most nursing and allied health professional notes were well completed and legible. Staff explained that changes in the paper records used was as a result of the integration with Bristol Royal Infirmary. Staff told us that it had taken some getting used to, as a small proportion of staff had received training on the use of the records.

We found that most medical records were clear, accurate, legible, and almost all were completed. However, we saw that some patients' medical plans lacked detail to inform care and treatment. Some nursing records were not fully completed for patients needing mental capacity assessments and venous thromboembolism (VTE) risk assessments.

An electronic records system had been implemented. This was a telephone sized piece of equipment held by each nurse. Staff confirmed that the connection to the server was rarely a problem, but if this was the case, a paper record would be maintained.

When patients transferred to a new team, there were no delays in staff accessing their records.

Medical staff completed discharge summaries for patients who were discharged from hospital. A copy was provided to the patient and another sent to their GP, to ensure important information about ongoing care was shared effectively.

Records were not all stored securely.

Patient paper records were stored securely but some computer records were visible to the public. Records were in paper format and kept in trolleys with number key code locks, which were secured when not in use. Staff we observed were mostly careful to ensure records were not left accessible and confidentiality was not compromised. However, on Sandford ward we saw that an electronic screen with patients' details was left visible for periods of time while staff left the area to continue working. This meant patients personal details could be accessed by anybody passing.

Medicines

The service used systems and processes to prescribe, administer, record and store medicines.

The service had systems and processes to administer and record medicines use, these processes were not always followed by staff and governance arrangements were not robust to identify and improve systems. Limited pharmacy workforce meant that patients did not always receive their medicines at the right time.

Staff did not always keep people safe by following systems and processes when prescribing, administering, recording and storing medicines.

During the inspection, we looked at seven medicine administration records. Medicines were prescribed on prescription and administration charts, including routine medicines that patients would take at home. However, in four cases there was no record that the patient took routine medicines. Two patients had routine medicines prescribed, but these medicines had not been administered. The reason for non-administration was not recorded for one of these patients. Another patient was not able to take a medicine as it had not been ordered from the pharmacy. One patient did not have a medicine given as the dose had not been recorded on the prescription chart. Where variable doses were prescribed, for example one or two tablets, the dose given was not always recorded.

Medical care (including older people's care)

Medicines advice and supply was available during weekdays and Saturday morning. An on-call pharmacist was available outside of core working hours. However, ward staff told us they could not always contact pharmacy if required for advice or medicines supply. Nurses on surgical day case unit reported that pharmacy did not respond to contact before 11am midweek.

Assessments to determine the risk of patients developing a venous thromboembolism (VTE) were not always completed or recorded. Medicines to prevent a VTE were sometimes prescribed without a recorded assessment. This meant it was not possible to tell if patients were receiving the right treatment according to their risk of developing a VTE.

Staff reviewed patients' medicines regularly but did not always provide specific advice to patients and carers about their medicines.

Prescribers recorded the indication and duration of treatment when prescribing antibiotics. Intravenous antibiotics were regularly reviewed and switched to oral preparations if appropriate.

Patients were not always provided with medicines counselling to explain changes in medicines or when new medicines were started. The healthcare assistant in the discharge lounge told us that no-one checked that patients who received their take home medicines in the discharge lounge understood how to take them at home. This was for patients who have got the take home medicines whilst in discharge lounge. There was some ward counselling from nurses and pharmacy.

The trust did not always store and manage all medicines and prescribing documents in line with the provider's policy.

We checked medicines storage arrangements in MAU, Sandford, surgical day case and the discharge lounge and found medicines were not always stored securely. On the medical admissions unit we saw that medicines waiting for return to the pharmacy, may be accessible to non-authorised staff, visitors and patients. There was no door on the treatment area where these medicines were stored. This had been identified on a safe and secure medicines audit in 2020, however, action had not been taken. We also found, there was no dedicated medicines storage area in the discharge lounge to store medicines, including controlled drugs or medicines needing fridge storage, while patients were waiting for transport.

Medicine trolleys and patient's bedside lockers were also used. Medicines stored in these areas were safe and secure.

Temperatures of medicines storage areas were not monitored to make sure medicines were being stored as recommended by the manufacturers. We found that medicines storage in the medical admissions unit felt hot and was in direct sunlight. Staff had no risk assessments or monitoring to show that medicines were stored at the recommended temperature. We raised this with the deputy lead pharmacist and the ward sister.

Prescription forms (FP10s) were stored securely and there was a robust system to track their use.

Staff did not always follow current national practice to check patients had the correct medicines.

Medicines reconciliation was completed in the medical admissions unit and Sandford ward. Medicines reconciliation is the process of accurately listing a patient's medicines. This could be done when the patient is admitted into the service or when their treatment changes. On Sandford ward, delays in receiving care notes meant that medicines reconciliation was sometimes delayed. Sandford didn't have a ward clerk which meant notes sometimes took a long time to arrive at

the ward when a person was admitted. This meant pharmacy technicians couldn't refer back to medicines prescribed during previous admissions. Queries identified on patients' prescriptions during medicines reconciliation were not followed up to make sure they were actioned and completed. If patients were receiving medical care overnight on the surgical day case unit, they would not receive a clinical pharmacy service.

Pharmacy staff used dashboards to identify patients to prioritise for medicines reconciliation. The percentage of patients having their medicines checked was improving, but there was still work to do to meet national best practice.

Medicines for discharge were dispensed from a transcription of the prescription chart. Staff told us that discharge summaries were not reliable to use as a source of medicines reconciliation.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

The medicines safety officer provided medicines communication and education across the trust and ensured that procedures were amended in line with any safety alerts and changes in guidance. Medicines incidents were investigated, and any learning shared.

Incidents

The service did not manage patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and returned the information, but this was not shared, and lessons were not learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

At our previous inspection in January 2021, we saw that the service had not always managed patient safety incidents well. Staff mostly recognised incidents but did not always report them. Lessons learned were not always shared with staff. At this inspection, we found that staff were reporting incidents, but there was very little feedback or learning evident to staff.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy.

Staff were encouraged to report incidents and other concerns. The trust policy was that every incident reported was looked at every working day by the divisional and corporate patient safety teams, in addition to the management of any required actions by the ward manager.

We saw examples of when staff reported shortages of staff on the wards. They used the electronic reporting system and submitted their alerts. The staff reported the incident which was then returned to the same staff member for investigation. When a response had been collated for that incident, they were submitted again. However, staff told us that the resubmitted responses did not go to the matron who was managing staffing. No further feedback was provided to the ward staff about these incidents and no learning outcomes or change of practice were evident to staff.

Managers did not share learning with their staff about never events that happened elsewhere.

An action plan was in progress to develop shared learning. There were also local safety messages, screen savers and safety huddles used in Weston Hospital.

Medical care (including older people's care)

Staff confirmed that they sometimes had updates from Weston Hospital areas but did not receive learning and updates regularly from other departments of the hospital and the wider trust.

Staff had not received feedback from investigation of incidents, both internal and external to the service.

Staff at Weston Hospital reported incidents well. From January 2020 to April 2021. The most reported type of incidents from Weston Hospital were pressure ulcer (meeting the serious incident criteria) (40%) and slips/trips/falls (27%).

Weston Hospital medicine directorate reported 15 incidents, and the most reported incidents were pressure damage to skin.

From January 2021 to June 2021, the trust reported zero never events for medicine. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong.

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 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.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The safety thermometer data showed the service achieved harm free care within the reporting period. Staff used the safety thermometer data to further improve services.

The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. The safety thermometer was used to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

All wards and departments displayed monthly safety audits at the ward entrance. This included the latest number of falls and pressure ulcers for the information of patients and their families and carers. The evidence provided showed that audits undertaken each month demonstrated a high level of achievement and success.

Is the service effective?

Requires Improvement

This was the first comprehensive inspection of this service.

Medical care (including older people's care)

We rated effective as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff followed policies to plan and deliver quality care according to best practice and national guidance.

Policies and guidelines had been developed in line with national policy. These included the National Institute for Health and Care Excellence (NICE) guidelines. We observed staff following NICE guidance CG139 Healthcare- associated infections: prevention and control in primary and community care when hand washing.

The endoscopy unit used the world health organisation (WHO) checklist for invasive procedures. The WHO guidance (2008) underpinned the process of theatre checks for safety with a standard operating procedure to ensure staff were aware of their responsibilities in line with national guidance.

Staff accessed clinical policies and procedures via the staff website for support. The system used allowed the addition of other local guidance and provided a library to link to audit projects.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service adjusted for patients' religious, cultural and other needs. This was not seen to be the same service provision for patients using escalation areas.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

Staff gathered patient information that informed them about patient's nutritional care and fluid needs and created a care plan for how they were to be met. We saw clear instructions recorded for patients with identified nutritional needs. The kitchen staff maintained a board that showed patients' diet needs. This was not available on escalation areas such as the surgical day case unit or the Geriatric Emergency Medicine (GEM) unit. There the management of nutrition was more reactive with patient's nutrition being supported without planning. This meant there was a risk that patients may not have what they needed or be delayed in receiving any special diets

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

The trust used a nationally recognised nutrition screening tool to identify patients at risk of being malnourished or with specialist nutritional needs. This screening tool was designed to categorise patients risk as being at low, medium or high risk and an appropriate care plan was completed.

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Nursing staff supported patients who needed assistance to eat and drink. Those patients needing assistance had food delivered on a red tray, to discreetly inform staff. The food and fluid charts we saw were kept up to date.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it.

Therapist were available including speech and language therapist and dietitians to support those patients who needed it. These therapists were available by referral and did not work out of hours or at weekends. For patients needing a swallow assessment, for example a patient having suffered a stroke, staff had been trained to enable this to be completed promptly. This meant patients did not have restrictions on eating and drinking over a weekend.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. Access to pharmacy support was not available in all escalation areas.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Staff used a pain assessment tool to identify the severity of patients' pain and we heard staff asking patients about their levels of pain. We saw from records that pain relief was given when needed.

Patients mostly received pain relief soon after requesting it. Staff prescribed, administered and recorded pain relief accurately.

Medicine charts reflected when and what medicine had been administered and the rationale for any omissions or delays. It was evident that escalation areas being used such as the GEMS unit and the surgical day case unit, did not have pharmacy support and so stocks of pain relief medicines were not available. These medicines, if needed, would have to be prescribed and so would create a delay for patients.

Patient outcomes

Staff monitored the effectiveness of care and treatment on the wards. They used the findings to make improvements and achieved good outcomes for patients. The trust submitted data to some national audits.

The service participated in relevant national clinical audits. Outcomes for patients did not all meet national standards.

National benchmarks such as the Myocardial Ischaemia National Audit programme in July 2020, showed that in some areas insufficient data had been submitted and other areas did not meet the standard.

The Heart Failure Audit produced in July 2019 showed that some areas performed better than others. Inpatients admitted with heart failure who received input from the specialist team and those patients who received cardiology follow up was worse than the national average, while those discharged on medicines for their condition was better than the national average.

Stroke services submitted data to the Sentinel Stroke National Audit Programme (SSNAP) 2019 audit and had a score of D, which meant that some aspects of the stroke service had room for improvement. These areas included the time spent on the stroke unit and the access to therapist. The data provided demonstrated good door to needle times. This meant that the time taken from the patient arriving at the hospital with symptoms to the start of treatment. This can be used to evaluate the quality of the stroke care provided.

Audit data for the trust prior to March 2020, for the Bristol Royal Infirmary and the Weston Hospital were published separately. From the March 2020 data set, it was a combined data which meant that each hospital could not directly identify how they were scoring. The Summary Hospital Mortality Indicator for UHBW for the 12 months to October 2020, was 89.8 and in the "as expected" category. This was better than the overall national peer group of English NHS trusts of 100.

Medical care (including older people's care)

During the pandemic, the National Clinical Audit & Patient Outcome Programme (NCAPOP) was effectively suspended. During this time, members of the trusts clinical audit and effectiveness team were re-deployed to support other key services. The trust maintained a small central team to continue to provide support, but much of the work had to be limited. The team were currently working through the national audits to update the latest positions. In August 2020, the trust purchased a new project management system and the implementation was planned to be in several phases. This included plans to streamline processes for assurance against national guidance.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers made sure staff understood information from the audits.

A structured approach was taken to ward based audits and produced daily, monthly and quarterly reports for cleanliness of the environment, hand hygiene, falls and infections. Dashboards were produced which showed audit activity and results.

Audits showed that delays in discharges had an impact on the hospital. The trust risk register identified as a high risk that some discharges of patients with complex needs did not occur in a timely manner. The data for delayed transfers of care showed that from April 2020 to March 2021, as a result of these delays there was a loss of 866 bed days to the trust. These delays meant that beds were not available for new patients to be admitted.

Some audits showed capacity issues at the hospital. Bed occupancy rates overnight showed that during 2019 to 2020 at Weston Hospital, occupancy rates were higher than the England average and higher than occupancy rates at the Bristol Royal Infirmary.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. The levels of appraisal and supervision varied.

At our previous inspection in January 2021, we saw that 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. This was because during the COVID-19 pandemic, patients were on non-medical wards. At this inspection we saw that this had improved. Patients had returned to the speciality wards, enabling nursing staff with appropriate medicine speciality skills to care for medically sick patients. This was except for the surgical day case unit, the GEM unit and the Waterside unit, which were not always staffed by nursing staff experienced or specifically skilled in the medical patient group.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave new staff an induction tailored to their role before they started work.

Staff had the right skills and knowledge to provide safe care and treatment for patients. Staff received induction and new staff we spoke said they were well supported by other staff. However, we were told by staff that two days "shadowing" another experienced staff member, was not enough for staff to feel competent. Staff explained that training was not a priority when busy and the training sessions were delayed.

There were varied levels of supervision to support staff.

NHS England had provided guidance to NHS trusts to pause appraisals between January 2020 to July 2020, and between 5 November 2020 to 25 March 2021 in order to respond to the pandemic.

Consultant supervisions were at 61% compliance and appraisal rates for nursing staff varied between wards. The lowest appraisal rates being on care of the elderly wards, the discharge lounge, Kewstoke ward and Sandford ward.

Some wards told us that team meetings did not take place regularly, often due to pressures on the service and staffing levels. They told us updates were provided when time allowed.

Registrars continued to lack access to training opportunities in their own specialty. They were required to cover medical duties and ward rounds during their day and due to their reduced number, they told us there was reduced time to dedicate to training.

In early 2021 junior doctors from the medicine department had mostly been removed This action was taken due to a lack of training and supervision for them which mean their learning needs could not be met. At the time of this inspection there were no confirmed plans for their return.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Specialist nurses provided training and guidance to staff when needed. Some staff had obtained additional qualifications, for example venepuncture and echocardiograph within their speciality.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. The escalation areas did not have the same multidisciplinary structures, due to the lack of medical staff allocated to them.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

Staff worked collaboratively to ensure continuity of care to patients and ensure the appropriate professionals were involved in care and treatment. Nursing, medical and therapy staff on wards and units worked together to facilitate care and treatment and assist patients to improve enough to go home.

Multidisciplinary team meetings took place on the wards to ensure a full medical overview was maintained and action plans completed. We attended a meeting where multiple agencies worked together to support the patients. Each patient identified for the meeting was discussed and the team looked at arrangements for their future care. Patients were spoken about respectfully and their views and that of their families, who would be providing ongoing support were considered.

Referrals to other agencies were discussed as well as mental capacity and any safeguards needed.

Staff worked across health care disciplines and with other agencies when required to care for patients.

Patients identified on admission as needing frailty support were seen in the emergency department and then transferred to an appropriate ward. There was no specific frailty area so the frailty consultant would visit patients across a range of wards. The frailty team consisted of two physiotherapists and two trained nurses. However, there was a lack

of geriatricians and geriatric frailty unit. Staff told us that a change in records being used meant that the scoring system for identification of frailty was no longer on the front of the admission documentation, so staff felt this had lost the visual prompt for staff to complete it. The inclusion of frailty as a mandatory record on the computer system had been used but had also been removed, this meant an opportunity was lost for a virtual oversight of frailty patients.

Oncology support was provided across the medical wards as there was no specific oncology ward. Chemotherapy could be administered at the day case unit, enabling patients to go home and attend daily for treatment. If a patient's chemotherapy regime lasted over three days, the trust policy was that patients would have to receive treatment at the Bristol Royal Infirmary.

Patients with a life limiting condition and who were at the end of life, were cared for by nursing staff across wards and received the specific support of the specialist palliative care team. The specialist palliative care team worked with the acute oncology team and were part of multidisciplinary team working to ensure patients received the care and treatment they needed. This team provided training and support for staff and for the use of pain-relieving delivery devices called syringe drivers.

Seven-day services

Key services were not all available seven days a week to support timely patient care.

Consultant led daily ward rounds did not take place each day on all wards, including weekends.

The provision of seven-day services is to ensure that patients receive consistent high-quality safe care every day of the week. Patients located on the medical admissions unit should be seen by a consultant each day and each patient should be reviewed within 14 hours of admission by a consultant and then referred to a speciality medicine consultant.

This provision was not maintained as there was no consultant presence on the medical assessment unit at the weekends. This meant decisions regarding patients ongoing care and treatment including transfer, discharge, referrals could be delayed.

The critical care outreach team were available 24 hours a day, and they undertook the assessment and development of treatment plans for patients needing critical care. They also worked with the non-invasive ventilation (NIV) nurse and provided support for staff for the use of NIV and oversaw all patients requiring ventilation support. The lead NIV nurse provided specific training to staff to enable safe management of NIV. They worked alone in this role at Weston Hospital but were integrating with the nurse holding the same position at Bristol Royal Infirmary. Over the period of the COVID-19 pandemic, they had trained 452 staff in the management of NIV. When NIV patients were admitted through the emergency department alerted the NIV nurse to ensure that they could locate them.

The NIV nurse had the support of a band eight physiotherapist. There was no specific NIV consultant available and support from the intensive care consultant was sought when needed. A clear plan was made for patients requiring NIV for the weekend. The nurse had developed a NIV care plan template for nursing and medical staff. This care plan and the subsequent outcomes were being audited and evidence indicated that at the last point of review in December 2020, there was 75% compliance with NIV national guidance. The NIV lead had instigated actions to work towards full compliance.

The medical day case unit provided a day facility Monday to Friday, to deliver infusions and transfusions to patients who could return home that day. This was a nurse led service to patients under care of gastroenterology, rheumatology, haematology and cardiology teams. The department was opened from 9am to 6pm.

Medical care (including older people's care)

Therapy staff provided care and treatment Monday to Friday, with a reduced service at the weekends and out of hours.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

The critical care outreach team were available to support patients and staff throughout the hospital seven days a week. The hospital at night team had been developed by the trust. This team included trained nurses and intensive care trained staff. They met each night with the outreach team to assess patients needing additional support and to plan how this would be managed overnight.

Patients had access to x-ray services 24 hours a day seven day a week, including diagnostic scanning services. However, out of hours there was availability for urgent scans only.

Staff had access to mental health liaison services seven days a week. Staff made referrals to the mental health liaison team, who would review and triage referrals each day. Out of hours a referral could be made but there would be a delay in the patients being seen until daytime working hours.

There was access to out of hours pharmacy support and an on-call pharmacist. Pharmacy was on site for clinical service and supply of stock medicines.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units.

Staff provided health promotion information for patients on wards. The previous access to written information in the form of leaflets had been discontinued during the COVID-19 pandemic as it present an infection control risk.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Staff assessed each patient when admitted and looked at aspects of health that created risks and looked at what support was available. We saw posters and information on wards promoting healthier lifestyles and directing patients to ask for more information. For example, one patient said, "I was on a particular diet before I came in, so I was really happy that I've had food to help me with this during my stay here."

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records.

We observed staff talking with patients and obtaining consent when providing care. As part of that engagement, staff were heard to ask patients for their understanding of the care to be given and their agreement and consent.

Medical care (including older people's care)

Staff were aware of policies regarding consent, mental capacity act and deprivation of liberty safeguards. We saw that when the safeguards were used, they were well recorded, and staff understood their scope of use.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care but there was not always a clear record of how decisions had been made.

The recording of mental capacity assessments was not well managed. The trust had a mental capacity act policy which stated that if a patient lacks the capacity then an assessment was required. Not all patients identified as lacking capacity to consent had a mental capacity assessment completed. This meant that there was no audit trail of how the decision about lack of capacity had been made and if the involvement of the patient had been considered. Staff told us that this shortfall had been created because the assessment template was now located in a different record.

Not all patients identified as lacking capacity to consent in the document used as a treatment escalation record had a mental capacity assessment completed. For example, we looked at two records on Sandford ward which identified the patient did not have capacity to make decisions about their care and treatment, but there was no assessment to identify how that decision had been made.

The patient's records noted that the patient did not have capacity by the word "No" being circled. There was no assessment document completed which would identify how that decision had been made and if the involvement of the patient had been considered.

Staff told us that this shortfall had been created because the assessment template was now located in a different record. They showed us this assessment in the admission booklet, it was a short series of questions which staff said was used to ascertain capacity. This change in paperwork had been implemented when the trusts had merged in April 2020. Staff explained that some changes in paper records had not been implemented with sufficient training for all staff and so some processes were not correctly followed.

Staff were not assessing patient's mental capacity to make decisions about medicines. For example, we saw that routine medicines for patients living with dementia were not given and the reason recorded as 'patient refused'. There was no assessment to determine if patients had the mental capacity to make that decision, or any recorded best interest decisions. We did not see any medicines specific mental capacity assessments.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

We saw that for one patient Deprivation of Liberty Safeguards had been completed.

On the medical assessment unit some patients came onto the ward with mental health issues. Staff could describe and knew how to access policies and get accurate advice about the Mental Capacity Act and Deprivation of Liberty Safeguards.

Is the service caring?

Good

Medical care (including older people's care)

This was the first comprehensive inspection of this service.

We rated caring as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients.

Patients spoke positively about the care they were receiving. One patient said, “They are quick to come if anything is wrong or if I press the call button. They always come by and check and ask if I am OK.” When one patient called out complaining of pain, staff responded quickly. The staff talked to them and checked the pain medicines that the patient was prescribed and explained that as they had been asleep, they hadn't had their pain medicine earlier on. They immediately went and got the medicine and ensured the patient had something to eat before taking it.

Patients privacy was protected because staff closed curtains around beds when giving personal care, or when having confidential conversations. Staff spoke softly to minimise the risk of other patients or visitors overhearing conversations.

Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients appreciated the time staff spent with them. One patient said, “Staff are very nice when they come along to see you and they do have a chat with us.” Nursing and cleaning staff were seen to take time to talk with patients while carrying out tasks on the wards. Patients responded positively to these conversations.

During our observations and interviews we could see that positive relationships had been built up between staff, patients and relatives. One patient said, “I will miss them when I leave here due to the fantastic care, they have given me. They are busy and short staffed and often get taken to help on other wards, but I've never overheard a miserable conversation from the nursing staff.”

Patients said staff treated them well and with kindness.

We saw staff providing kind and thoughtful care. One patient said, “Staff are busy but always courteous.” Another patient said, “They're all lovely to me and get to know our names and I get to know their names.” During our observations a patient walked slowly with a walking frame. Staff walked by the side of them with a hand gently on their hip for support. They gave constant encouragement to the patient, not rushing them and letting them move in their own time.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff took time to explain to someone why they needed to clean their bed. They made several attempts to explain to them and respected and listened to what the patient said back to them. Patient dignity was protected during these discussions because staff closed the curtains around beds. We heard staff explain to patients what they wanted to do and asking for their permission before doing it, for example before taking someone’s socks off as they were getting into bed. The patient refused and staff did not press the issue when the person wanted to leave them on.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Patients told us that their needs and preferences had been respected and met by staff. A patient said, “I do things when I want to do them, not when the nurses want me to do things - like washing and showering. I just need to tell the nurse beforehand and they accommodate as much as they can.”

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

During a multidisciplinary team meeting, staff discussed the emotional needs of patients and if there was anything that could be done to support them. A multidisciplinary team meeting is where a group of professionals from one or more clinical disciplines come together make to decisions regarding recommended treatment of individual patients. For example, one patient had worries about going home and a discussion took place into what could be done to help them and increase their confidence.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Nursing staff and representatives of different faiths were available to offer support to patients, relatives and staff in times of need. There was always a Chaplain on call should patients or relatives request their presence. There was a multi faith area available for prayers or quiet reflection and an on-call list for leaders of other faiths should they be needed. The hospital Chaplain described a recent occasion when an Iman had been called and together with the support of the translation services had supported a patient and their relatives. The Chaplain provided pastoral care for staff, as well as patients and would come in when needed out of their normal hours. They explained to us that during COVID-19 a lot of support had been needed.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them.

Staff talked about patients compassionately and with knowledge of their circumstances and those of their families. One patient said, “The staff feel like a family working together and they all give good care.”

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment.

Staff involved patients in discussions about their care. One patient said, “They keep me informed about what is happening to me and I ask questions if I'm not sure - they've given me a list of what medicines I'm taking and I do feel involved in what is happening to me.” Staff were observed talking with a patient and their relative about the possibility of going home. Staff asked the patient if they felt well enough and could they cope at home. They discussed options with them and checks that they may need to do with the patient such as seeing them walk before they could go home. The person was fully involved in the conversation and their family member was also involved.

Medical care (including older people's care)

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients felt included in the decisions about their care. One patient said, “The doctors are good they make sure I understand what they're saying. I was impressed as they showed me all the charts and explained it all to me.”

Where patients first language may not be English, translators had been arranged to support. The trust had a communication team who staff could contact for help and guidance. One staff member explained, “We arranged a translator for a patient, who came in most days so the patient could understand what we said. The patient’s family came in to support and assist the patient for the days that the translator couldn't be there.” Additionally, communication cards had been put into place so the patient could communicate directly if the translator or family were not around. This enabled staff to ask questions around pain management, and if the patient needed anything such as the toilet, food or a drink.

Staff supported patients to make informed decisions about their care.

Patients felt included in decisions about their care. One patient said, “They tell me the reason why they want to do things, like when taking my blood pressure and I am aware I can say no if I want to.” During our observations staff were heard to give information to patients about care and support, and they listened to and respected the patient’s decision.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Patients felt able and supported to give feedback. A patient said, “I know how to make a complaint and I would feel comfortable doing that.” Feedback forms could be completed when patients left the hospital, and the results were posted for others to see. Outside ward entrances noticeboard displayed the latest patient feedback using a ‘You said, we did’ format. Additionally, on one of the wards, a display had been arranged to show the many thank you cards had been received, along with excerpts of the feedback given.

The hospital sought views of patients and relatives by use of the Friends and Family Test. The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way to give your views after receiving NHS care or treatment. From December 2020 to May 2021, 285 responses for medical care had been received, with a 93% positive score achieved.

Patients gave positive feedback about the service.

A relative said, “They have been absolutely brilliant here, every one of them.” Written feedback from patients included, “I witnessed nurses caring and talking to patients like they were their own parents and family” and, “Thank you for the brilliant care you gave and your kindness and support to me - You went out of your way to keep me informed on progress.”

Is the service responsive?

Requires Improvement

Medical care (including older people's care)

This was the first comprehensive inspection of this service.

We rated responsive as requires improvement.

Service planning and delivery to meet the needs of the local people

The service did not always respond in a timely way to meet the needs of local people and the communities it served. It worked with others in the wider system and local organisations to plan care.

There was limited planning to meet the needs of the local population.

There was no visible planning to manage the increased demand for beds in the hospital. The use of predictor tools to identify the level of probable admissions each day, did not prompt action to meet the demand. The bed management team were under considerable pressure to find beds for patient admissions, but the lack of movement in the hospital made this difficult. Bed management staff told us they were supported by clinical commissioners to find safe discharge routes out into the community. However, systems in the hospital did not support weekend discharges or promote early ward rounds to enable discharges on the same day.

Planning for next winters pressures had not been considered. Staff told us that the winter plan was not yet being considered and that last winter's plan document had been delayed in being available.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

Patients were cared for in either female or male (single sex) bays wherever possible. Every effort was made to support care to be provided in single sex areas including escalation areas.

Facilities and premises were not all appropriate for the services being delivered.

Some areas of care were seen to not provide an appropriate environment, facilities or service for patients. The facilities used as escalation areas to enable patients to be admitted while they waited for a speciality bed or to be discharged, were not suitable for this purpose.

The trust had a discharge lounge where patients who were clinically stable and ready for discharge, could be transferred to while they waited for ongoing care. The discharge lounge had a standard operating procedure to outline the number of patients and the scope of its use. The lounge was located some distance from other ward areas and was staffed by a healthcare assistant and had no pharmacy provision. This meant that when patients arrived for discharge without their take home medicines, the health care assistant had to leave the area to collect them. This left patients unobserved for periods of time.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

The service had arrangements, known to most staff on duty, to meet patients' urgent mental health care needs, including outside office hours and in an emergency.

The service relieved pressure on other departments when they could treat patients in a day.

Medical care (including older people's care)

The ambulatory care area was used whenever safely possible, to treat patients and return them home. The area was staffed by nursing staff and was planned to lighten the pressure on the emergency department and medical services. Staff confirmed that its level of use was variable.

The medical day case unit was available to support patients who required infusions and transfusions who could return home each evening.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet their needs.

Ward staff considered how to meet the needs of patients living with dementia. Staff had completed some dementia care training and were using this to consider patient's needs. For example, staff described how they supported patients who wanted to walk and used this as an opportunity to interact by looking at paintings on the walls and trying to make the walking purposeful.

Staff understood and applied the trusts guidelines on meeting the information and communication needs of patients with a disability or sensory loss.

Staff were aware of how to support patients with additional communication needs. Staff described how to access interpretation services and the gave examples of when language helplines had been needed to interpret medical and care needs.

Access and flow

People could not always access the service when they needed it and did not all receive the right care promptly.

Patients could not always access and receive treatment in the right speciality ward or area.

We saw the systems used to promote flow through the hospital, were not all effective and the increasing demand outweighed the available capacity. Throughout our inspection, the hospital had 100% bed occupancy with no beds available (with the exception of one designated COVID–19 bed) for any admissions.

Senior leaders at the hospital understood that to continue to provide care for patients, the model needed to change. Prior to the COVID-19 pandemic, the hospital was calculated to have between 30 and 40 beds short of what they needed to meet the needs of the local community. Since that time up to 30 further beds had been lost to achieve social distancing. Extra beds have been used to meet escalating needs by using up to five beds on the surgical day case unit and three beds on the Geriatric Emergency Medicine (GEM) unit. We saw that a private ward of single rooms had created 11 bed spaces. These spaces were not ideally placed, staffed or equipped to meet patient's needs.

The hospital had problems maintaining flow from admission to timely discharge. This was caused in part by the trust not having sufficient beds available to meet demand. There was a further reduction in beds available due to COVID-19 restrictions and the need to create socially distance bed spaces. There were other contributing factors for example, ward

rounds carried out later in the day which impacted on discharge timeliness and there were reduced numbers of medical staff with the authority to discharge patients. Reduced medical and nursing staffing, meant a lack of staff available to implement patient discharge plans. There were also delays in discharges to the community, as there were difficulties accessing resources for continued care.

Managers monitored waiting times but could not ensure patients could access emergency services when needed or receive treatment within agreed timeframes and national targets.

The hospital monitored the demand on its service, and this demonstrated that it was a higher demand than it could meet. The Operational Pressures Escalation Framework (OPEL) detailed how the trust identified and responded to pressures within its system daily, as well as at times of extraordinary pressure. This framework relates to adult beds and includes medical beds. Each day bed meetings took place at 08:30 and 16:00, to review the flow of patients through the hospital. Those meetings were attended by bed managers and department nurses in charge. Some staff attended virtually.

From September 2020 to May 2021 (with a gap in available data for January and February 2021) the OPEL framework had reached level three for 33 days and the highest level, OPEL 4, on eight days. This indicated the high level of pressure the hospital had been under.

Managers and staff worked to make sure patients did not stay longer than they needed to but this was not achieved.

While considerable work was undertaken to reduce length of stay, we saw that some patients stayed longer than needed. This was due in some part to lack of beds in the hospital and as onward care was delayed. For example, in May 2021 there were 213 patients who experienced a delayed discharge. This created many days when beds were not available for patients coming into the hospital.

The service moved patients only when there was a clear medical reason or in their best interest. Staff confirmed that movement of patients was not always suitable or appropriate.

Patients' bed moves were avoided whenever possible but were taking place both during the day and night-time. Staff told us that bed moves at night varied but were minimised when possible. Discharging patients out of hours was undertaken in both day and evening time. The trust policy stated that patients should not be moved after 10pm.

The movement of patients at night was not always suitable or appropriate. Staff told us of occasions when patients were moved very late at night, to enable further admissions to the hospital. For example, a patient who was unsteady and was receiving enhanced supervised care was transferred at 11:45 pm from a medical ward to a surgical ward to free up space for a new medical admission patient. Because of the late hour their family had not been informed until the following day.

There were not always arrangements for doctors to review outlying medical patients.

The trust had a policy for staff to follow for management of outlier patients, but this was not always followed. This policy had specific criteria to define the safety considerations needed but not all areas of the policy were followed. There were not always clear arrangements for medical cover, which put patients at risk of delayed care.

Medical care (including older people's care)

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with staff.

Patients, relatives and carers knew how to complain or raise concerns.

Patients knew how to make a complaint and felt they could raise concerns with staff. Patients, carers and relatives were able to complain by letter, email, telephone, via the Patient Advice Liaison Service or in person to any member of staff. Leaflets describing how to complain were no longer available on the wards due to infection control measures. Staff described the process they would follow to try and resolve any issues locally and directly and advise patients of how to escalate their concerns if not satisfied.

Staff understood the policy on complaints and knew how to handle them.

The trust risk register identified a high risk that the Weston divisional complaints process was inadequate. From May 2020 to April 2021, across the Weston hospital there had been 250 complaints, of which 133 were formal complaints. It was not possible to identify which of these complaints were related to the medicine division. Of those formal complaints, 39% were responded to within the trust and divisional timescales. It was also noted that 11% of complaints were dissatisfied with the response they had received from the trust about their complaint.

Managers investigated complaints and identified themes. Managers did not always share wider trust feedback from complaints with staff and learning was not always used to improve the service.

Staff told us that they may get learning from their own ward investigations but that they had not received learning from the wider trust. Staff could give examples of how they used patient feedback from their own wards to improve daily practice. For example, staff explained that concerns raised about patients' pressure damage were actioned immediately and learning was used in future practice.

Is the service well-led?

Inadequate

This was the first comprehensive inspection of this service.

We rated well-led as inadequate.

Leadership

At our previous inspection in January 2021, we saw that leaders at Weston Hospital did not demonstrate that they had 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 for staff. The trust's senior leadership team were perceived not to be present enough on the wards to understand the issues staff faced. At this inspection, staff told us very little had changed, but staff recognised at ward level that integration with Bristol Royal Infirmary was in its infancy and changes were starting to happen.

Medical care (including older people's care)

Leaders had the skills and abilities to run the service but had not managed the priorities and issues the service faced. They were developing a visible approach in the service, which was not yet evident to all staff.

The senior leadership team at Weston Hospital and board members from the trust were not known to staff.

The Weston Hospital division of University Hospitals Bristol and Weston NHS Trust was led by a divisional director, a head of nursing, and a clinical chairperson. This triumvirate approach had been used since the creation of the Weston division in April 2020. This senior leadership team oversaw services running from the Weston Hospital site. All posts in Weston triumvirate had been appointed to, with additional support in place via deployment of the Deputy Chief Nurse and Deputy Medical Director for periods of time.

The senior management team considered that they were working together to look after staff.We spoke with many staff and were told they could not recognise the senior leadership team and did not know their names. They told us they did not attend their departments and were not familiar to them.

We met with the senior management team who described the hospitals difficulties with change as the two hospitals integrated. They recognised that leaders had different managerial capacity to manage change and so some difficulties had been experienced. The senior team recognised that visibility during the COVID-19 pandemic had been an issue and while they were still not a recognised visible presence on the wards, some inroads had been commenced to meet with staff.

At ward level staff felt supported and listened too, but there was a disconnect between the ward level staff and the senior leadership within the trust.

None of the staff we spoke with knew who the trust board were and told us they never saw members of the board on the wards. This was except for the chief nurse. Staff told us their leadership came from matrons and ward managers and not from higher in the trust.

There appeared to be a disconnect between Weston senior management team and ward staff. The senior management team recognised that the issues of staffing at Weston Hospital were a priority. Staff told us they did not know if leaders prioritised or were aware of the pressure the reduced staffing was having on them. The senior management team told us that they understood that without improved staffing, staff and services would continue to be under pressure. They were looking at ways to make Weston Hospital a more attractive place to work. They had recruited from overseas and looked forward to that increased nursing support. However, while these actions were ongoing, the staff remained in the same position and without evident visible senior management team leadership.

The leadership team were developing ways to engage with staff. A staff forum had been set up with meetings every two weeks to try and engage with staff. There had been an attendance of 10 to 15 staff members. We asked staff about this forum however, the staff we spoke with did not know about this. Social media was starting to be used to reach staff and leaders considered the feedback from this forum to be valuable. A record was being maintained to demonstrate actions taken as a result of this feedback.

Vision and Strategy

At our previous inspection in January 2021, we saw that staff did not know or understand what the trust's vision, values or strategy were, or what their role was in achieving them. At this inspection we saw that little had changed. 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.

Medical care (including older people's care)

The trust had a vision for what it wanted to achieve and a strategy to turn it into action. This vision and strategy was not developed with Weston Hospital staff and was not known by staff there.

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

Staff told us there was little collaboration to create or understand the vision, values and strategy for the new organisation, and they did not know how they fitted into the structure. This view was held by some from staff despite the evidence provided by the Trust demonstrating extensive engagement with staff at Weston both pre and post merger. Some staff were aware of the PRIDE vision which had been the vision for the Weston General Hospital prior to the merger and some were able to tell us mostly what it meant; some, however, were unaware of the vision and strategy of University Hospitals Bristol and Weston.

The PRIDE vision is:

People - Showing high care standards or specifically helping a patient, visitor or colleague

Reputation – Actions that have helped to maintain the Trust's good name in the community

Innovation – Showing a fresh approach or finding a new solution to a problem

Dignity – Contributing to the Trust's Dignity in Care priorities

Excellence – Being considered 'excellent'

Senior leaders recognised they needed to create and promote the vision and accelerate the strategy for Weston Hospital. Most of the staff we spoke with did not know the vision for trust or the strategy to achieve it.

The trust had an implementation plan which outlined the requirements and stages for the integration of clinical and corporate services. Staff understood that the integration of the hospitals into one trust would require changes to be made, but some felt that the way changes were made was not supportive of them. They told us that they felt that some practices being changed had not needed changing. For example, they told us that training to use new paperwork was not provided to all staff and this increased pressure on them. They described systems to access equipment had been changed, which created delays they had not previously experienced.

Culture

Staff all expressed that they loved working at the hospital but did not feel respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work.

At our previous inspection in January 2021, we saw that staff did not always feel respected, supported and valued. Staff were focused on the needs of patients receiving care, this was despite feeling isolated and lacking supportive leadership. At this inspection, we saw that although the pressures of the pandemic were receding, staff were tired, and morale was low.

The culture centred on the needs and experiences of people who use services.

Medical care (including older people's care)

All staff spoke positively about patient care and how patients were the centre of their focus. They were proud of the team working and felt reassured by the feedback from patients.

One member of staff summed up a collective response from staff we spoke with when they said, “It’s a lovely hospital, the medical and nursing staff are begging for help”.

The trust risk register noted as a high risk that there was low morale and engagement with staff.

The staff turnover rate was 27.9% and the vacancy rate was 17.8%. Areas with the highest staff turnover were Berrow ward, Draycott ward, Sandford ward and medical staff across the medicine services. These were higher levels compared to Bristol Royal Infirmary, where staff turnover was 18% and the staff vacancy rate was 9%.

There were cooperative, supportive and appreciative relationships among staff.

Staff felt pride in their role and work they undertook; this was despite feeling isolated and lacking supportive leadership. We saw staff look after each other by taking on extra work to support their teams. However, we were told that staff took on extra shifts to support their team but became disgruntled when they were then moved to work on wards they did not know. They considered this detrimental to their team working.

Staff were aware of how to speak out about their concerns but felt it did not prompt change.

Staff appeared to have the systems to enable them to speak up, but they said there was little point as they felt nothing changed. Data provided by the trust showed that when staff at Weston Hospital had raised concerns via the Freedom to Speak Up Guardian, action had been taken. Staff were aware of the trust’s freedom to speak up guardian, who provided independent and impartial support to workers to speak up. Patients and relatives, we spoke with told us they felt confident about speaking up without fear.

Staff received training on, and understood, the duty of candour. We heard of examples of staff having applied the duty of candour in response to incidents.

Governance

At our previous inspection in January 2021, we saw that governance processes were not effective in developing the service. Staff 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. At this inspection, we saw that the governance systems were not seen to have supported changes to the service.

Governance systems were not used to support the development of a quality service. Learning from the performance of the service was not always maintained.

The governance was not used to develop the service and address the issues impacting on the service and staff. Although it was acknowledged by managers that governance systems needed to be improved, there was no evidence that systems were regularly reviewed, or any plans were put to support improvement.

Medical care leaders were not managing identified issues early or promptly enough to prevent them from becoming problems. We also saw that when relevant risks and issues were raised and actions identified to reduce their impact, these were not acted upon to prevent ongoing safety risks.

As examples:

Escalation areas did not always have safe nursing levels and identified and named medical staff available and this placed patients at risk. The divisional risk register identified some patient risks, but these did not include the risk of not being able to staff the escalation areas. The Quality and safety committee meeting records did not reflect the risks associated with using the escalation areas.

Not all ward areas met the planned safe nursing staffing levels identified by the trust. When this was escalated, appropriate action was not taken. The Quality & Safety Committee meeting minutes showed that in February 2021, staff reported 19 incidents of lower than expected staffing levels for nursing. This increased in March 2021 to 34 incidents reported. The systems used to review how staffing was managed, were not effective to create change and improve the quality of service provision.

The management of the Waterside unit had not been reviewed to establish the quality and safety of the service being provided. The Quality & Safety Committee meeting minutes showed that the Waterside unit consistently had some of the highest levels of incident reporting in the Weston medicine division, however, this was not reflected in actions taken to promote safety.

Governance systems did not ensure actions were completed. The risk registers and risk assessments used to monitor the ward and unit environments and the action needed for safety, did not ensure agreed actions were completed. The acknowledged issues including the Waterside unit visibility access windows and the call bell in the discharge lounge had not been actioned.

The systems used to monitor consultant availability and accessibility had not been measured. This meant that the standard operating procedures implemented to ensure consultant behaviours were standardised and quality standards met, had not been overseen. We saw that there remained no consultants available on the medical assessment unit at the weekends and so patients were not seen by a consultant within 24 hours of admission there.

There remained reduced oversight by registrar level doctors of junior doctors' practice due to lack of staff available. As a result, no audits had been completed of junior staff work to ensure that they received appropriate feedback to support improvement. We saw that registrars were very busy and so there was limited capacity to do this and senior management team had not facilitated any action to address this issue.

There were no audits of the changes to documentation to ensure that the changes were effective for patients, especially those lacking mental capacity. This meant that patients may not have been involved in decisions made about them.

Governance processes were not effective in developing the service.

The trust's risk register noted as a high risk that the governance systems and process were not fully established and embedded through the Weston division, from speciality level through to divisional board. 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 safer staffing, but safer staffing was not happening on the wards and staff did not feel involved or updated on developments to improve staffing.

Incident reporting of staffing issues did not create a change in staffing levels. Staff demonstrated that reporting staffing issues did not make any changes to the practices and was not used for learning.

Nursing staff told us that staffing constraints meant that while they audited their own wards for safety and quality; they received little learning and had limited engagement in the monitoring of the quality of the wider hospital services.

Medical staff could not support governance, as well as clinical work due to capacity constraints caused by insufficient staffing and demand on the service.

Performance review meetings did not reflect the service provided.

The division held monthly quality and safety committee meetings. The quality and safety team undertake analysis of key metrics, comprehensive overview of patient outcomes, staff experience and share this information with the internal governance team.

We saw some records for the quality and safety divisional meeting minutes. These records looked at the incidents and safety issues for the division. However, they did not include the safety issues we noted at inspection, for example the use of unsafe areas for outliers or staffing levels. We noted that outlier areas were not included in the incident reporting data. The minutes for these meetings for January to February 2021, noted that feedback from ward teams had highlighted a gap between the investigation of incidents and the wider dissemination of learning. As a result, bimonthly meetings were planned to be held with ward staff in the divisions to share relevant incidents raised / lessons learned and restorative actions being taken. Staff told us this had not yet happened.

The trust planned an internal audit of governance processes. This would include an executive led monthly performance management review of quality governance, performance and finance, corporate patient safety group and quality & safety committee. This had not yet been implemented and so the trust does not yet have that facility to provide itself with assurance.

Management of risk, 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.

At our previous inspection in January 2021, we saw that although leaders and teams identified and escalated relevant risks, issues and identified actions to reduce their impact; these were not always revisited in times of crisis. At this inspection, we saw that management of risk continued to be reactive instead of being planned and managed in a safe way.

There was not always a planned management of risk.

The trust recognised further work was required to enhance risk identification, mitigation and reporting throughout the division. The trust told us about a risk management policy used, which described the processes for managing risk. It was proposed to undertake a review of the existing risk reporting to identify any further gaps and actions required.

The management of risk did not ensure that those risks known were acted on in a timely way or that learning was taken to change future practice.

We reviewed the Emergency Clinical Governance and Risk Group minutes for the previous five meetings. None of the issues we found during our inspection such as the flow of patients through the hospital, escalation spaces opened for outlier patients and the need for some areas to have safety work completed were mentioned. This demonstrated the governance processes were not effective at identifying risks.

The trust provided us with the risk register for the Weston division, which noted some risks had not been reviewed by the target date or did not have a target date. This meant the trust could not be assured that risks were treated with the required urgency or acted upon promptly. At this inspection we saw that some risks recorded were not acted upon in a timely and responsive way to ensure patient safety. For example, in January 2021 the lack of windows in doors and lack of patient monitors on the Waterside unit was recorded, but when we visited this area five months later, these issues had not been actioned.

The management of issues and performance continued to present a challenge to the trust.

The stroke service had not completed enough thrombolysis procedures in the last year. The recommended amount was 600 procedures and the location had completed 240. The trust had not raised this on their risk register as a concern.

The endoscopy unit has Joint Advisory Group (JAG) accreditation. To gain this accreditation, the unit was assessed against several national standards and continued to monitor its own service provision to ensure compliance. A review of this award was due in April 2021.

Leaders explained recruitment was a challenge and the service were not meeting this challenge. There was little time for staff involvement in governance and opportunities for discussions to look at management of performance. Staff told us they felt that they were trying to solve problems in isolation. Doctors were struggling with one consultant covering wards and the registrars were busy covering multiple wards. The pressures of working in the reduced staff numbers had impacted on development and shared learning.

Information Management

The service collected data and analysed it. The information systems were secure. Data was consistently submitted to external organisations as required.

At our previous inspection in January 2021, we saw that information was not always handled in line with information governance requirements. At this inspection we mostly saw records were stored securely however, screens with patient information were sometimes left unattended and so accessible.

Data was gathered and used to look at themes and trends across the trust. The medicine division had a dashboard which identified levels of sickness for staff, appraisal compliance, training compliance, turnover rate and vacancy rates for staff.

The Quality and Safety report for the medical division meeting for February 2021, records incidents and those showing increased levels of incidents and includes themes and trends.

A dashboard was used to look at audit outcomes and where action was needed. Notifications were submitted when needed to ensure that recordable information was gathered.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.

Patient and visitor engagement had prompted some ward changes. We saw that in one instance a patient expressed that they were bored. In response there was free WIFI implemented and access to an electronic tablet for music and movies and further resources of books and magazines were supplied.

Medical care (including older people's care)

In line with guidance from NHS England, the Friends and Family Test was suspended during the COVID-19 pandemic and formal submission restarted for December 2020 data in January 2021. From December 2020 to May 2021, Weston medical care had 285 responses, of which 265 would recommend the service.

The trust board papers for March 2021 stated that integration of the division of Weston into the trust's patient experience programme continued to be a key priority; specifically, extending the current Bristol Royal Infirmary postal survey process for inpatients and outpatients to replace the existing exit survey at Weston, to create comparable data across the hospitals.

Engagement with staff was being developed. The leadership team were seeing developments through a staff forum, however staff we spoke with did not know about the forum and so far, the leadership team confirmed around 15 staff had attended each session.

Staff felt that retention of staff was not considered and that engagement to find out why this was, had not been considered. Staff explained that a high level of staff had left, and they were still leaving. Staff felt that attempts to retain staff at Weston Hospital had not been considered. The staff turnover rate and vacancy rate was seen to be higher at Weston Hospital than the Bristol Royal Infirmary.

The trust had put in some systems to support junior doctor issues. Weekly Wednesday afternoon 'junior doctor clinics' commenced early February 2021; where juniors were encouraged to attend to feedback any issues and concerns and to receive information on current challenges. This clinical discussion group was led by the Deputy Medical Director.

A recruitment video for Weston Hospital had been completed as part of the leadership teams' efforts to make Weston Hospital an attractive for newly qualified nurses to come and work there.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services.

Staff were enthusiastic about developing their own services and were keen to tell us about the ideas they had and how they wanted to drive them forward. For example, a member of staff had developed a sepsis project with an allocated project manager supplied from the Bristol quality improvement team. There were three workstreams – identifying patients, education of staff and educating patients while in hospital. The project team included consultants, doctors, nurses and was ready to go. Unfortunately, the project had been stopped with no reason given and staff were hoping to hear that they could proceed.

Outpatients

Good

Is the service safe?

Good

We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training. Most staff were up to date with the trust's mandatory training programme or had dates booked to attend training in the near future. This meant that most staff were up-to-date with their skills and knowledge to enable them to care for patients appropriately.

The mandatory training was comprehensive and met the needs of patients and staff. Most staff told us mandatory training updates were delivered to meet their needs and they were able to access training as they needed it.

There were a range of topics including equality, diversity and human rights, health and safety infection prevention and control, information governance, conflict resolution, and adult basic life support. Mandatory training was available using a range of methods to maximise accessibility, including face-to-face sessions and e-learning. Staff also had the option to complete training at home if they preferred.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training performance reports were available to review training attendance and staff could check their compliance with mandatory training. This supported the appraisal discussion and personal development planning. Managers saw which members of their team were in date and were able to plan when team members needed to complete refresher training. Email reminders were sent to all staff reminding them in advance of when the training was due. Compliance was reported monthly to the trust board as part of the governance report.

The trust set a target of 85% for completion of mandatory training for all courses. The compliance rate for the period from May 2020 to April 2021 ranged from 85.7% to 100% with six modules having 100% compliance.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing and medical staff received training specific for their role on how to recognise and report abuse. Safeguarding training completion rates showed 100% compliance for safeguarding adults and children, level two.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were knowledgeable about the trust's safeguarding policy and processes and were clear about their responsibilities. They described what actions they would take should they have safeguarding concerns about a patient. All staff were confident to challenge to ensure the safety of patients.

Outpatients

Staff followed safe procedures for children visiting the departments. The trust provided information to staff within safeguarding policies and procedures. This included the action to take when staff had concerns regarding child protection and domestic abuse.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. In all areas we visited, the floors, walls, curtains, trolleys and areas in general were visibly clean.

The service generally performed well for cleanliness. The service used a ward inspection application to capture information about infection control and cleanliness on smartphones or tablets. Data for cleanliness of scopes and wipe systems, hand hygiene and donning of personal protective equipment (PPE) showed 100% compliance.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. There were dedicated teams of a housekeeper and cleaning staff who ensured the areas were clean and tidy and they were fully integrated with the clinical teams. There were daily schedules and weekly tasks, alongside deep cleaning as and when required. Cleaning staff were able to show us their work schedules. Cleaning equipment was colour coded, clean and well maintained, and stored in a locked area. Workloads were high in all areas as a result of COVID-19 requirements.

Staff followed infection control principles including the use of personal protective equipment (PPE), such as face masks, gloves and aprons. These were readily available to staff. There were PPE stations in each consulting room. There were infection prevention and control champions in the departments who were available to remind all staff, patients and visitors to follow Public Health England COVID-19 advice.

Waiting chairs were cleaned regularly with wipes and a bell would be rung every hour to remind staff to clean the surfaces in the waiting room.

Staff, patients and visitors to the ward had access to antibacterial gel and handwashing facilities. We saw these used regularly throughout our inspection. Nursing and medical staff washed their hands and applied antibacterial hand gel between each patient contact. We also saw non-clinical staff, including reception and administrative staff and cleaning staff using hand gel. The antibacterial hand gel was located at the entrance to the hospital and throughout the outpatient departments.

Patients were asked to complete COVID-19 screening questionnaires on arrival in order to identify and isolate anyone who may have COVID-19 symptoms.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance. The service was divided into a main outpatient department and the Quantock department.

Outpatients

In response to COVID-19, risk assessments had been completed for all outpatient environments to maintain social distancing. A self-assessment tool had been completed for each outpatient department to consider the adjustments that needed to be made to support social distancing.

Patients and visitors were provided with guidance on attending outpatient appointments through the trust website, appointment leaflets, appointment letters and signage across the trust.

Chairs in the waiting areas were appropriately spaced to observe social distancing requirements. Protective screens had been installed at reception desks and signage on walls and floors had been installed to reflect the current COVID-19 requirements.

The service had enough suitable equipment to help them to safely care for patients. There was access to emergency equipment. The emergency trolleys in both departments were clean, tamper evident and ready to use. Staff carried out daily and weekly checks of the equipment and medicines to ensure they were ready to use and in date. This was evidenced by the signature of the staff member carrying out the check. From the records we reviewed during a three-month period there were no gaps in the log.

We saw a range of equipment was readily available and most staff said they had access to the equipment they needed for the care and treatment of patients in all specialties.

Staff carried out daily safety checks of specialist equipment. There were regular inspections to identify any faulty equipment and this was removed from use and the fault reported. As part of a ward inspection application, there were monthly inspections to assess the condition of the patient chairs or couches. Compliance was at 100%.

Staff disposed of clinical waste safely. Disposable items of equipment were discarded appropriately, either in clinical waste bins or sharp instrument containers. Nursing staff said these were emptied regularly and none of the bins or containers we saw were unacceptably full.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Risk assessments relating to patients needs were completed and evaluated. There were clear processes to deal with patients where their medical condition was deteriorating.

Staff responded promptly to any sudden deterioration in a patient's health. Staff knew about and dealt with any specific risk issues. Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them appropriately. A flow chart supported staff to follow the process.

Staff shared key information to keep patients safe when handing over their care to others. A number of standard operating processes had been introduced in response to COVID-19 working arrangements. These included a framework for patients in the 'shielded' and 'very high risk' category who needed to attend and another to assess if patients were presenting with symptoms of COVID-19 or had contact with others presenting with symptoms prior to attending their appointment. Others related to patients requiring a bone marrow aspiration and for the protection of vulnerable patients who arrived unwell.

Outpatients

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants

and healthcare assistants needed in accordance with national guidance. There was a process for

monitoring and ensuring safe staffing in line with current national recommendations and this was

reviewed monthly by the head of nursing.

Managers could adjust staffing levels daily according to the needs of patients. Daily nurse staffing was monitored and reviewed to ensure the right staff were in the right place at the right time. This was confirmed through senior oversight by the senior sister and matron against a standard operating procedure for safe staffing.

There was a mix of skilled and experienced nurses and healthcare assistants in both departments. There were senior nursing staff in band eight (matron), band seven (senior sister) band six (sisters) and supporting band five (nurses). The band seven nurse oversaw the day-to-day running of the nursing teams in the departments.

Data from May 2020 to April 2021 showed the service had low turnover rates and most staff had been part of the team for many years. There was a 14% vacancy rate with 3.44 full time equivalent (FTE) vacancies out of a budgeted 24.4 9 FTE, of which 25% vacancy rate 2.03 FTE out of a budgeted 8.11 FTE, was for registered nurses.

The service had a 12.1% sickness rates as a result of long-term sickness absence, which was being managed in line with trust policy.

Managers limited their use of bank staff and requested staff familiar with the service. There was no agency use with shifts being covered by bank staff.

Staff said they had been stretched at times during the last year when capacity and demand had been consistently high as a result of COVID-19.

Medical staffing

We were not able to see any data to show there were enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Despite our requests to see data showing the number of medical staff working in the service, the trust were unable to easily provide this information due to the way information was collated. Information about vacancy or turnover rates, sickness rates, or the level of bank and locum staff was also unavailable.

However, managers were assured there were enough staff to keep patients safe and staff were similarly positive about the staffing numbers.

Staff said there had been use of locums during the last year when additional medical staff were needed. They had received a full induction to the service before they started work.

Outpatients

Records

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

Patient notes were comprehensive and all staff could access them easily. We reviewed ten sets of patient records. They had a standard layout and format which assisted the clinician to locate the information they needed specific to the patient's condition.

All notes were signed and dated. Information was complete and concise and care plans were up to date. The records were well completed and reflected the needs of patients. Each set of records provided detail of the care and treatment plan and included information. Completion of records was regularly audited and actions taken to address any shortfalls.

Consent forms for sharing information and consent for procedures were completed. All patients had a recommended summary plan for emergency care (ReSPECT) form at the front of the notes.

Records were stored securely. Cabinets and trolleys were locked and could only be accessed by appropriate people.

When patients transferred to a new team, there were no delays in staff accessing their records. Patient's records could be tracked and located using a tracer system. On occasions when records had not been correctly tracked for outpatient attendance, staff said it was easily rectified and did not cause any delays in treatment.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicines were stored securely in locked cupboards and trolleys and doors were locked to treatment rooms with access restricted to appropriate staff. There were no controlled drugs. Regular balance checks were performed in line with trust policy. The cupboards were well organised and functional.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Prescriptions were dispensed in the hospital pharmacy. These were signed, dated and logged. Prescription forms (FP10s) were stored securely and there was a robust system to track their use.

Medicines refrigerators and treatment room temperature records showed medicines were stored at the correct temperatures. There were weekly medicine audits where all medicines were checked, discarded if out of date and reordered.

Nursing and medical staff had access to pharmacists who were available between 8.30am and 5pm on Monday to Friday.

Staff followed current national practice to check patients had the correct medicines. Policies and procedures were available and accessible to staff on the trust intranet. Policies we viewed as part of our inspection were in date and in line with best practice and national guidelines. Information was also available to all staff.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff knew how to report incidents or near misses on the trust's electronic reporting system. Staff felt confident in raising an incident should they need to. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Outpatients

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff reported serious incidents clearly and in line with trust policy. There were systems to make sure incidents were reported and investigated appropriately. Staff were open, transparent and honest about reporting incidents and said they would have no hesitation in reporting incidents and were clear about how they would report them. All staff received training on incident reporting.

Staff knew what incidents to report and how to report them. All incidents were reported directly onto the incident reporting system. This provided a single record of each incident, subsequent investigation, agreed learning, and evidence of the learning and its effectiveness.

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff said they were encouraged to report incidents promptly.

The service had no never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Although we did not see any examples of where duty of candour had been applied, staff demonstrated an understanding of their responsibilities and could describe the process and what they would do. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Staff received feedback from investigation of incidents in the outpatient service. Learning from incidents started at the point where the event happened, with any necessary local action being taken to minimise a similar event from reoccurring.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. The incident reporting policy set out the processes for reporting and managing incidents and described the root cause analysis investigation process and the roles and responsibilities of staff involved in the process.

Managers debriefed and supported staff after any serious incident. Staff confirmed they received feedback after reporting an incident and an action plan was shared. Learning was shared using a variety of methods. Firstly, there was an immediate response and any local action taken to help prevent a reoccurrence and formal feedback methods such as team meetings to help spread any learnings from events.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Safety thermometer data was displayed in the department for staff and patients to see.

Outpatients

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

We saw that a safety audit was completed monthly and included; infection, prevention and control, hand hygiene and equipment. During the months of April and May 2021, the department had been 100% in compliance with these audits. The department had introduced the National Safety Standards for Invasive Procedures (NatSSIPs) checks for hysteroscopy (a hysteroscopy is a procedure used to examine the inside of the womb using a hysteroscope) and flexible cystoscopy (flexible cystoscopy is an examination of the interior of the bladder with a fine, soft tube with a telescopic camera called a flexible cystoscope). This was not a national requirement for these particular procedures and we saw that in April, March and May 2021 the department had 100% compliance.

Is the service effective?

Good

This was the first comprehensive inspection of this service.

We rated it as good. There was insufficient information to rate this question previously.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies, care and treatment pathways, and clinical protocols had been developed in line with national best practice recommendations. These included the National Institute for Health and Care Excellence (NICE).

Policies were available to all staff on the trust intranet system and staff demonstrated they knew how to access them.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink. Including those with specialist nutrition and hydration needs. Packed lunches and drinks were provided for patients who were attending for lengthy periods. Vending machines were also located in both outpatient departments.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it.

Pain relief

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

Outpatients

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. There was guidance in care plans about pain management for patients where it was appropriate. Patients had their pain assessed and appropriate methods of reducing pain were offered.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. There was an annual audit plan which enabled the service to benchmark the standard of care provided at the trust against local and national standards. For example, the service participated in the national inflammatory arthritis audit and the fracture liaison audit. Local audits included nurse and nursing assistants competency assessments for; flexible cystoscopy (flexible cystoscopy is an examination of the interior of the bladder with a fine, soft tube with a telescopic camera called a flexible cystoscope), venepuncture (venepuncture is the process of obtaining intravenous access, most commonly for the purpose of blood sampling) and for the administration of topical eye drops.

Managers used information from the audits to improve care and treatment. Audits were monitored and action plans to address areas of improvement were regularly reviewed.

Outcomes for patients were positive, consistent and met expectations, such as national standards. The service participated in national safety standards for invasive procedures (NatSSIPS) with consistently positive outcomes.

Managers shared and made sure staff understood information from the audits. Information was shared at unit meetings and by email. Staff confirmed they were kept up to date with results and any actions required.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service. Data showed 80% of staff had received an appraisal and others had dates booked in the near future.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Clinical supervision enabled staff and managers to identify training needs, develop competence and enhance clinical practice. Most staff were positive about the frequency of clinical supervision they received.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Minutes of meetings were emailed to all staff and a paper version was available for staff to read.

Managers gave all new staff a full induction tailored to their role before they started work. Staff confirmed they received a comprehensive induction. They felt confident and prepared to work in the departments.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work.

Outpatients

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. There was a commitment to training and education within the service. Staff told us they were encouraged and supported with training and there was good teamwork. Staff were encouraged to keep up to date with their continuing professional development and there were opportunities to attend external training and development in specific areas.

There was a trust-wide electronic staff record where all training attended was documented. Managers were informed of training completed and alerted to those staff requiring updates for mandatory training through regular competency reports.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. For example, a new rolling trainee programme had been introduced for a trainee role in the fracture clinic plaster room. This ensured cover was available during periods of absence.

Managers made sure staff received any specialist training for their role. The service undertook a range of education and practice development activities aimed at enhancing the knowledge, skills and awareness and development of the staff.

Ophthalmologists peer reviewed and audited each other's work monthly. Phlebotomists and plaster room technicians did the same in their peer groups.

There were service specific competency assessments for nurses and nursing assistants, for example in hysteroscopy and flexi-cystoscopy, spirometry, vision field training and orthopaedics.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. There were multidisciplinary (MDT) integrated clinical pathways to improve the patient outcomes. Staff worked across health care disciplines and with other agencies when required to care for patients.

Patients could see all the health professionals involved in their care at one-stop clinics. For example, diagnostic tests would be scheduled at the same time as other appointments to ensure patients could make one visit to the hospital.

Staff referred patients for mental health assessments when they showed signs of mental ill health.

Seven-day services

Key services were not available seven days. The departments were open on weekdays from 8.30am to 6.30pm.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support in patient areas.

Outpatients

Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle. Health promotion was a routine part of all care provided to patients. All staff worked collaboratively to assess aspects of general health and to provide support and advice to promote healthy lifestyles.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff said they were confident in making capacity assessments.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Throughout the inspection we saw staff explaining the assessment and consent process to patients and any need to share information with other professionals such as GPs, before obtaining written consent.

Staff made sure patients consented to treatment based on all the information available. Staff said they obtained consent from patients prior to commencing care or treatment. They said patients were given choices when they accessed their service.

Staff clearly recorded consent in the patients' records. This was clearly recorded in all the records we reviewed.

When patients could not give consent, staff made decisions in their best interests, taking into account patients' wishes, culture and traditions.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff were aware there were additional steps to consider if the patient did not consent to treatment. Staff contacted the approved mental health practitioner team at the local mental health trust.

Is the service caring?

Good

This was the first comprehensive inspection of this service.

We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Outpatients

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. During our inspection we observed positive interactions between staff and patients. Staff were open, friendly and approachable and interactions were very caring, respectful and compassionate.

Patients said staff treated them well and with kindness. Care from the nursing, medical staff and support staff was delivered with kindness and patience. The atmosphere was calm and professional, without losing warmth. Staff were focused on the needs of the patients and ensured they felt respected and valued as individuals.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. They were knowledgeable about the trust framework to support communication with families who were non-English speakers, or for whom English was a second language. Support was also available for patients with hearing or visual impairment, or who had learning disabilities.

The comments we received from patients were unanimously positive. They spoke positively about their experience in the hospital from staff at the front door, the reception staff and consultants and nurses. They confirmed the staff were kind and helpful to them. We observed medical and nursing staff interacting and engaging with patients.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff providing emotional support to patients during their visit to the departments. Patients individual concerns were promptly identified and responded to in a positive and reassuring way.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Throughout our inspection, we saw patients being treated with dignity and respect. Voices were lowered to avoid confidential or private information being overheard despite the difficulties of COVID-19 measures i.e. wearing face masks and having perspex screens at reception. All patients said their privacy and dignity was maintained.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Difficult information was discussed in a sensitive manner and a patient told us how supportive the entire team had been when they delivered such information.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. Patients were spoken with in an unhurried manner and staff checked if information was understood. Staff talked about patients compassionately and with knowledge of their circumstances and those of their families.

There was good support from the hospital multi-faith chaplaincy team who were available in the hospital during normal office hours.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Outpatients

Staff made sure patients and those close to them understood their care and treatment. Patients were involved with their care and decisions taken. Patients said all procedures had been explained and they felt included in the treatment plan and were well informed.

Staff talked with patients in a way they could understand, using communication aids where necessary. We observed staff explaining things to patients in a way they could understand to help them become partners in their care and treatment.

Staff supported patients to make informed decisions about their care. Patients were encouraged to be involved in their care as much as they felt able to. Staff recognised when patients needed additional support to help them understand and be involved in their care and treatment. Staff showed understanding and a non-judgmental attitude when caring for or talking about patients with mental health needs, learning disabilities or autism.

Patients gave positive feedback about the service. The trust used the NHS friends and family test to find out if patients would recommend their services to friends and family if they needed similar treatment or care. A high proportion of patients gave positive feedback about the service in the test.

The trust used a separate patient experience programme to gather patients' feedback about their experience. There was a separate measure for kindness and understanding. Responses exceeded the trust target score of 90 or over.

Is the service responsive?

Requires Improvement

This was the first comprehensive inspection of this service.

We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that sometimes met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

All aspects of outpatient performance continued to be heavily impacted by COVID-19. Initially capacity was lost due to additional infection prevention and control measures, a shortfall of staff, social distancing and patient choice not to attend. As a result, services did not always meet people's needs.

Managers were planning and organising services to meet the needs of the local population and the changing COVID-19 situation. The trust launched an elective restoration programme in April 2021, led by members of the senior leadership team, to coordinate recovery activities based on the core priorities of patient safety, workforce, capacity and capability.

The plans included extending endoscopy opening times, standardising waiting list initiatives, maximising the utilisation of rooms and adapting the space where possible, increasing advice and guidance and deploying more specialties to patient initiative follow-ups. Face-to-face appointments were also a priority while retaining the option of virtual and telephone appointments.

Outpatients

The team were involved in developing plans for integration of clinical services and were working to re-design the programme to achieve the goal of completing all service integrations by March 2022.

The planned service transfer of the Weston urology service to a neighbouring trust remained a key priority. It had been delayed but was now expected to go ahead in autumn 2021.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. One stop appointments were arranged to avoid multiple attendance for vulnerable patients. For example, diagnostic tests and appointments with a urology consultant were arranged on the same day.

During the last year, a number of processes had been adjusted to ensure patient's safety during the pandemic. For example, shielding patients arriving for blood tests were advised to wait in their car in a disabled bay in the car park. A phlebotomist would call the patient in through fire exit door located next to the treatment room.

Facilities and premises were appropriate for the services being delivered. The trust had been mindful to support vulnerable patients attending outpatient appointments during the pandemic. This included new patient information leaflets to provide reassurance and revised letters and text messages to keep patients informed about accessing services. There was clear signage and staff greeted patients at the front door and guided them to the outpatient departments.

Staff could access emergency mental health support for patients with mental health problems, learning disabilities and dementia. There were arrangements to meet patient's urgent or emergency mental health care needs from the local mental health team.

Managers monitored and took action to minimise missed appointments. Patients were sent text reminders about their appointments. Where patients cancelled an appointment at the last minute, a same day appointment could be offered to other local patients who were available at short notice.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. There were dementia champions to support patients who visited the departments. Two appointment slots would be booked for patients requiring more time and a quiet space would be set aside, where possible. However, referrers in the community did not always alert the team about patient's needs prior to their booking and staff, on occasions, had to be very creative in supporting patients on arrival.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The access to the department and use of equipment met the needs of patients and visitors with a disability.

The service had information leaflets available in languages spoken by the patients and local community. This ensured patients and their families and carers had access to written information about their illness and/or conditions.

Outpatients

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Support was available for communication with patients and carers for whom English was a second language, people with hearing or visual impairment, or who had learning disabilities. There was telephone interpreting, video conferencing and written translation services. Face-to-face interpretation had been suspended as a result of COVID-19 working arrangements. Information could also be provided in large print, in braille, or a British Sign Language interpreter was available.

The hospital's chaplaincy team provided pastoral support and spiritual care to patients and their families. They provided support for all faiths (and none) and maintained close contact with faith leaders in the community. There was a chapel on the hospital site open at all times.

Access and flow

Some people were not able to access the service when they needed it and did not receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Although we found the service largely responded well, not all referral to treatment times were meeting national targets and some elements required improvement. All aspects of outpatient referral to treatment time (RTT) performance continued to be heavily impacted by COVID-19.

Outpatient referrals and outpatient attendances had not returned to the pre-COVID-19 levels of 2019/2020. Data showed there were 96,947 outpatient appointments (including non-attendances and cancellations) from April 2020 to December 2020. Data at the end of March 2021 showed performance was at 57% of previous levels.

Managers monitored waiting times and were taking actions to improve patients' access to services within agreed timeframes and national targets. The key considerations for outpatients were tackling each of the specialty backlogs and reinstating pre-COVID-19 activity.

Patient pathways and flow through the outpatient departments had been reviewed. There were recovery trajectories and although these had started to perform better than at the same point last year, this was not sufficient to recover the backlog of waiting lists.

Managers were concerned if the service was unable to provide sufficient capacity to meet the demand, it would fail to achieve the RTT recovery trajectory, and would continue to be in a position where waiting times lengthened and patients would continue to wait longer for treatment. This had the potential to impact on the clinical outcomes for patients.

The national standard for referral to treatment times (RTT) pathway and the percentage waiting less than 18 weeks was that over 92% of the patients should be waiting under 18 weeks. NHS England / Improvement also issued guidance that trusts should aim to reduce the overall waiting list size, with trusts being expected to reduce volume from the end of January 2020.

From April 2021 targets had been set at 70% of the baseline 2020 position; then each consecutive month the position had to increase by 5% until the end of July; if this figure was achieved the trust would be eligible for the Elective Recovery Fund (ERF); this was an incentive scheme for system providers.

Outpatients

From March 2020 to February 2021, the referral to treatment time (RTT) for non-admitted pathways had been lower than the England overall performance.

The 18-week performance deteriorated in May 2020, with the lowest performance reported in August 2020 (50%). Performance then started to improve again with non-admitted patients treated within 18 weeks in October 2020 at (65.2%). However, performance deteriorated again for the seventh consecutive month to 49.7% in April, with 927 patients waiting over 52 weeks (12 % of the total list size). Around 13% of the longest waiting patients were currently choosing to delay their treatment due to COVID-19 related concerns, being unable to isolate or waiting to receive both doses of the COVID-19 vaccination before commencing treatment.

Endoscopy (including cystoscopy) continued to improve with 42.38% of patients managed within the 6-week standard. Job plans and scheduling for the endoscopy suite was under review and there was work underway with the Bristol site to confirm ongoing access to the independent sector.

In February 2021, 535 patients who were treated in a non-admitted setting had waited over 52 weeks for their treatment, compared to four in February 2020. In February 2021 this represented 6.2% of all patients treated in a non-admitted session. Specialties with the most non-admitted patients treated at 52 weeks or more were ophthalmology, and trauma and orthopaedics.

The average performance for cancer waiting times as a percentage of patients seen within two weeks of an urgent GP referral was below the 93% operational standard. However, in February 2021, 96.2% of patients were seen by a specialist within two weeks of an urgent GP referral. This was higher than both the south west average and the England average.

In the most recent reported quarter, the trust performed above the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis. The operational standard was not met in February 2021 with 92.2% of patients receiving a first definitive treatment within 31 days of a decision to treat. This was below the south west average and the England average.

In the latest reported quarter, the trust performed similar to the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral.

Managers explained cancer performance over the summer might be impacted if demand increased above normal variation, due to ‘pent up demand’ as lockdown eased. This was a particular risk for dermatology services, which always saw a large seasonal increase in demand in the same time period. Services were being encouraged to have contingency plans to enable capacity to be flexed up in response to demand surges, although it was recognised that such flexibility was limited whilst COVID-19 precautions were needed.

As a result of the COVID -19 response there had been a loss of capacity in outpatients for follow up appointments. Outpatient activity had not exceeded pre-COVID-19 levels, except in March 2021.

Provisional data for April 2021 showed outpatient attendances were around 90% of April 2019 levels. It was felt this would not provide sufficient capacity to manage the follow up backlog demand as well as the ongoing new demand. Capacity was being focussed on the delivery of the most clinically urgent cases and harm reviews were conducted to minimise risks to patients experiencing long waits.

Outpatients

There had been significant expansion of non face-to-face appointments. 32% of outpatients appointments were now routinely delivered in this way. This had been 3% pre-COVID-19. This was predominantly telephone clinic activity. Video consultation (attend anywhere) had been rolled out trust wide. Patient survey results showed a positive response, with 89% saying they would happily have another video appointment.

Access to an advice and guidance platform had seen a significant increase in requests during the last year. The average response time was 2.5 days. Patient survey results about the effectiveness of the service had been positive.

There was flexibility in most specialties to offer a range of appointments, although this could be difficult for urgent clinics such as diabetes foot clinic. The team did their utmost to accommodate patient's preferences for morning or afternoon appointments. Rheumatology clinics had been scheduled specifically in the afternoon as these patients often had mobility difficulties and found it easier to attend afternoon appointments.

The consultants had been proactive and flexible in working with the team to look at their job plans for their specialty. As a result, extended clinics and flexible lists had been agreed.

The service used an e-referral system. Consultants triaged all patients based on their previous medical history, family and social history. The consultant could either agree with the GP or request a different appointment, such as face-to-face, telephone, delay for three months, change or reject the referral.

There was a centralised appointment centre and patient access team who managed waiting lists. The patient access system had migrated from one system to another to be in line with the system in Bristol. The team would make up to three separate attempts to contact patients at different times of day, by phone and text message.

Following the migration to the new patient system, data quality issues had been uncovered where waiting lists totals were incorrect. An external validation had been undertaken to gain an accurate reflection. As a result, the number of patients experiencing long waits for an appointment had been reduced from 9,000 to 5,500.

Managers worked to minimise the number of cancelled appointments. Cancellation rates were starting to normalise and did not attend (DNA) rates were moving towards the figures seen before COVID-19. The Access Team made every effort to telephone and speak with patients to book appointments to help reduce DNA rates. Improvements had been seen since the return of text reminders. The DNA target at trust level was to be below 6.7%, with an amber tolerance of between 6.7% and 7.2%. In March 2021, the DNA rate was 6.4% across Bristol and Weston sites.

For appointments cancelled by the trust, the target was to be on or below 9.7% with an amber tolerance from 10.7% to 9.7%. The hospital cancellation rate was 10.1% and every effort was made to rebook an appointment within three months.

We spoke with patients who said, given the restrictions as a result of COVID-19, they were satisfied with the speed of appointments and waiting times were kept to a minimum, and they were always informed if the clinics were running late.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Outpatients

Patients, relatives and carers knew how to complain or raise concerns. Patients said they felt they could raise concerns with the clinical staff they met. Most patients told us if any issues arose, they would talk to the senior nurse available.

The service clearly displayed information about how to raise a concern in patient areas. Information about making complaints was available in all the areas we visited. Leaflets were available in all departments and information could be accessed on the trust website with links about how to resolve concerns quickly and how to make a complaint.

Staff understood the policy on complaints and knew how to handle them. There were policies and processes to appropriately investigate, monitor and evaluate patient's complaints.

Managers investigated complaints and identified themes. During complaint investigations staff were required to provide comments, and when indicated, written statements. The complaints and Patient Advice and Liaison Service (PALS) supported the trust in the delivery of the complaints investigation policy.

There had been 52 formal and informal investigations complaints. The categories with the most complaints related to appointments (17), attitude and communication (17), and clinical care (13).

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff were aware of complaints and any learning that had resulted. All staff we spoke with were aware of the complaints system within the trust and the service provided. They were able to explain what they would do when concerns were raised by patients. They said they would always try to resolve any concerns as soon as they were raised, but should the patient remain unhappy, they would be directed to the manager or the trust complaints' process.

Managers shared feedback from complaints with staff and learning was used to improve the service. Every complaint and PALS concern was reviewed to identify the issues raised by the complainant to ensure learning and continuous improvement.

Is the service well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The leadership of outpatients at the Weston site consisted of the divisional director and deputy divisional director of surgery; they were supported by an assistant general manager and three band seven specialty managers. Weston outpatients sat within the surgical division.

Outpatients

Senior managers had the right skills and abilities to run a service providing high quality and sustainable care. The consultants and senior sister were an experienced and strong team with a commitment to the patients who used the service, and to their staff and each other. It was an integrated and strong team with an emphasis on providing consistent and high-quality care.

The members of the senior management team were relatively new in post. They were embedding as a team and making progress with confidence, a clear structure and lines of responsibility. They were proceeding with cautious optimism to restore services. They were keen to listen to the lessons learned during COVID-19 and wanted to harness the enthusiasm and commitment of the new team. However, the specialty managers had fixed term contracts and there was uncertainty about the future of their roles, which posed a risk to their resilience and retention as a team in the future.

The leadership teams of managers, medical and nursing staff clearly understood the challenges in restoring the service and delivering good quality care. They were engaged with the programme to integrate services with the larger Bristol site and could identify the opportunities in sharing knowledge and skills. However, they were frustrated about the pace of change and the dilution of their autonomy to make changes at a local level. They were concerned about decisions being centralised in the larger Bristol site and preferred to retain control and management at a local level.

The team were knowledgeable and passionate about the service and actively worked to improve delivery of care. They were visible and available to staff, and we heard about support for all members of staff in the departments.

Staff said managers were approachable and they felt able to openly discuss issues and concerns with senior staff and their managers. They believed they would be listened to, and actions taken when necessary if anything needed to change or be addressed. The senior management team communicated with staff by email and face-to-face.

The senior sister operated an ‘open door’ policy, which staff were positive about. Staff were supported to develop their skills and competencies within their roles and with a view to internal promotion. We received consistently positive feedback from staff who had a high regard and respect for their managers.

Managers encouraged learning and a culture of openness and transparency. They had an awareness that staff required different leadership styles and were flexible in their approach to the needs of their teams.

All staff we met said they felt valued and part of the team and were proud to work in the team. They felt supported by the senior management team, senior sister and their colleagues.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

At trust level, there was an outpatient steering group with divisional and clinical representation. The team contributed to the healthier together outpatient group at a system level.

An outpatient redesign programme had been developed in collaboration with system partners.

The key priorities for the programme were restoration, delivery of patient initiated follow up and the roll out of community phlebotomy.

Outpatients

Managers had ambitious plans and recovery trajectories for the coming year and expected to be in a more comfortable position next year. These plans relied on the retention and knowledge of the team. Managers acknowledged reserves were limited and the team were working at maximum capacity.

There was a programme of integration of clinical services between the Weston division and the wider trust and another local trust. There was a standardisation of clinical operating processes and patient pathways, for example, ophthalmology, trauma and orthopaedics, gynaecology and ear nose and throat (ENT).

There were plans to merge the electronic referral service with the wider UHBW service, and to integrate the patient access teams. Managers were exploring the use of the independent sector as part of their recovery plans.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Managers encouraged learning and a culture of openness and transparency. Senior staff agreed that staff or teams would speak up to them when they needed to and would be heard. Staff said they were encouraged to speak up and felt comfortable about raising any concerns. Staff were also aware they could raise concerns about patient care and safety, or any other anxieties they had with the Freedom to Speak Up Guardian.

Staff talked with us about how the trust would share learning and take action when a never event, serious incident, or near miss occurred.

The team was positive about their role and felt supported to deliver care to patients**.** All the staff we met said they felt valued, confident and proud of the care they provided. The team told us they were proud of being able to make a difference and felt supported by the leadership team and their colleagues.

Patients and their families were at the centre of the service. There was an emphasis on the importance of education and awareness for patients and their families. During our conversations with staff and observations on the departments it was clear staff had the patients at the centre of their work. They were passionate about services for patients and were dedicated to their roles and approached their work with flexibility.

The team provided support to each other. It was clear their work was important to them and they felt passionate about their contribution to care and were committed to improving the health of local patients.

Managers said they were proud of the staff they supervised. They said there was a high level of commitment to providing quality outpatient services. In addition, managers explained a number of staff had volunteered to move to inpatient areas at the height of COVID-19 and had shown great resilience and commitment to the wider trust during a time of crisis and had made a real difference.

Staff were positive about working for the trust, although there had been times when they felt stretched and under pressure during the last year. Many staff had worked in the departments for some time and were very proud of their length of service.

Staff felt listened to and were encouraged to make suggestions and to develop services. One member of staff explained how she had been supported with an idea to develop a service.

Staff were aware of the whistleblowing policies and procedures and felt able to approach managers to raise any concerns or suggestions and were confident they would be listened to and action taken.

There was an opportunity for staff to access support and debriefing when this was required. The trust also had a staff support/counselling service available to all staff.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Leaders operated effective governance processes. There was a clear governance structure driving change. Staff at all levels were clear about their responsibilities, roles and accountability within the governance framework.

There was a clear performance management reporting structure with monthly governance meetings looking at operational performance. This included a review of incidents reported, complaints, staffing, audit status, infection control, risks identified on the risk register and risk management, and education and training.

An extensive set of policies was readily available on the intranet and was supported by standard operating procedures and processes.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The trust had systems for identifying risks and plans to eliminate or reduce them. The service maintained a local service level risk register which clearly identified individual risks and the action taken to mitigate the risks. The position was monitored at monthly meetings.

The service monitored the effectiveness of care, treatment and performance. The service took part in national and local audits and evidence of improvements or trends were monitored. Performance data and quality management information was collated and examined to look for trends, identify areas of good practice, or question any poor results.

There were local contingency plans for the department if there were significant capacity and staffing issues, and problems with equipment. Actions were described for staff to follow and escalate depending on the status of the situation.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The information systems were integrated and secure. The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Outpatients

Staff had access to information they required to provide good patient care. All staff had access to the trust's intranet, which contained the information and guidance for staff to carry out their duties. Staff we spoke with were familiar with the trust intranet and knew where to find the information they needed.

Staff had access to information about patients to ensure they had sufficient and up-to-date knowledge to provide safe care and treatment. Staff used electronic systems to manage patient information such as referrals to the specialist care teams and to gain access to information about results of investigations such as blood tests.

As some clinics were run by another local trust, there were two patient access systems. This had initially caused problems for staff due to limited access to systems. This had been resolved with the purchase of additional licences to use the system.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

In line with guidance from NHS England / Improvement, the Friends and Family Test was suspended during the COVID-19 pandemic and formal submission restarted in December 2020. Data from December 2020 to May 2021 showed 95.3% of patients would be likely to recommend the service.

A patient experience survey was also implemented to fall in line with systems in Bristol. This included for the first time postal survey data for April 2021 for patients seen in Weston. The five topics included the things patients said mattered most to them. The overall score was 90 out of 100 and exceeded the trust target of 85. There was a separate measure for kindness and understanding, with a target score of 90 or over. Performance for April 2021 showed a score of 92.

A dip in patient experience scores had coincided with the first lockdown and uncertainty concerning COVID-19. Scores had improved in recent months being driven by patient reported waiting times being much reduced and the availability of non face-to-face appointments.

There were concerns about groups of patients being disadvantaged in terms of accessing technology. The trust were looking at the demographics and to hone responses to cater for these groups.

There were effective systems to engage with staff. In the NHS 2020 staff survey, in the question asked of staff whether they would be happy about the standard of care provided to a relative or friend by the organisation, 81% of staff said they would. This was against a sector average of 75%.

There were regular meetings to discuss, share information and provide feedback to staff. Minutes were taken of each meeting and emailed to staff and paper copies were available to ensure those that could not attend had access to the information.

Staff told us they felt engaged, informed and up to date with what was happening within the wider trust. Information was shared through different forums. These included unit meetings, secure social media pages, verbally and through the recently improved staff forum.

Staff said they were encouraged to speak up and voice their suggestions and solutions.

Staff had access to health and wellbeing services. There were informal reflective debrief sessions and counselling services were available through the occupational health service. A quiet room in the Macmillan Centre had been repurposed into a wellbeing hub for staff during the height of the pandemic. Staff rest areas and shower facilities had improved, and an extended covered area in the staff restaurant would be developed in the near future.

Staff told us about random acts of kindness from their managers, for example a cup with coffee / tea with a meaningful individual handwritten note of appreciation for staff efforts during the last year. Other initiatives included a nurse of the week and the outpatient team had been awarded a team spirit award in the pride awards.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

There was an emphasis for continuous, evidence-based improvement for improved health and better care. Staff told us they were always keen to learn and develop the service.

Innovation and improvement were encouraged with a positive approach to achieving best practice. There was a clear, systematic and proactive approach to seeking out and embedding new and more sustainable models of care to ensure the delivery of high-quality care for patients. Staff and managers felt there was scope and a willingness amongst the team to develop services through training and research and by learning from when things went well and when they went wrong.

There were a number of examples of innovations. These included:

- The development of a phlebotomy hub in the hospital car park to avoid vulnerable patients entering the hospital. Patients made an appointment with a time slot and waited in their car. Staff took a note of their number plate and returned to collect and escort them to the hub. Bloods were taken and patients were able to leave straight away. This was standard practice for the last year and only stopped when patients no longer had to shield. Patient feedback had been very positive. There were future plans to develop community phlebotomy hubs across the local area.
- As a result of limited face-to-face appointments for dermatology patients, YouTube videos were provided by clinicians to guide patients to check their skin and lymph nodes. This had proved to be popular with over 127,000 views.

UHBW Bristol Main Site

Bristol Royal Infirmary
Upper Maudlin Street
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Tel: 01179230000
www.uhbw.nhs.uk

Description of this hospital

On 1 April 2020, University Hospitals Bristol NHS Foundation Trust and Weston Area Health NHS Trust merged to form a new organisation, University Hospitals Bristol and Weston NHS Foundation Trust (UHBW).

The University Hospitals Bristol Main Site campus comprises:

- Bristol Royal Infirmary
- Bristol Eye Hospitals
- Bristol Haematology and Oncology Centre
- Bristol Heart Institute
- Bristol Royal Hospital for Children
- St Michaels Hospital
- Central Health Clinic

We rated the medical care core service at UHBW Bristol Main Site as good for the effective, caring, responsive and well led domains and requires improvement for the safe domain.

Therefore, our rating of this location stayed the same.

We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.

Our findings

- Staff treated patients with compassion and kindness, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's values, and how to apply them in their work. Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and staff were committed to improving services continually.

However:

- The service provided mandatory training in key skills to staff but not all staff had completed it.
- Premises were not always being used for their intended purpose. For example, additional bed spaces added to wards could compromise patient care and privacy.
- Medical staff did not always receive appraisals.

Medical care (including older people's care)

Good  

Is the service safe?

Requires Improvement 

Our rating of safe went down. We rated it as requires improvement.

Mandatory Training

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

Most nursing staff kept up to date with mandatory training. The overall trust target for compliance with training in key skills was 90%. Compliance was met within the specialised service division where the overall completion rate was 92%. The trust compliance target had just been missed for nursing staff across the medicine division with an overall 89% completion rate.

Staff were provided with e-learning packages which allowed them to complete training virtually. Some face-to-face training had been cancelled due to the COVID-19 pandemic which had impacted upon completion rates. As a result, there were significant gaps in training within both divisions, particularly around safeguarding adults' level three training, basic and intermediate life support training and fire safety.

Leaders told us extra training sessions were being provided and staff were given time to complete mandatory training in order to 'catch up'. However, staff told us it was difficult to find the time to complete training due to staffing pressures.

Medical staff had not all received and kept up to date with their mandatory training. The overall trust target for compliance with training in key skills was 90%. This had not been achieved for medical staff across both the specialised services and medicine divisions. Within the medicine division there was a 66% overall completion rate and within specialised services there was a 70% overall completion rate. There were significant gaps in training around fire safety, life support and safeguarding training.

Medical staff told us they felt well supported to undertake their training. However, there had been pressure on time during the pandemic and some face-to-face training had been suspended.

The mandatory training was comprehensive and met the needs of patients and staff. Staff told us the content of training was appropriate. Nursing staff told us face to face training, such as immediate life support training was well received as it was presented well and informative.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training compliance was recorded on an electronic system, which sent out automatic emails to staff to remind them to complete their training. Each division monitored their essential training compliance rates through monthly workforce reports, which were presented to the divisional board.

Staff told us they received emails and their managers were supporting them to complete essential learning that had been missed due to the COVID-19 pandemic and the increased demand on services.

Training compliance was recorded as a risk on the divisional risk register for medicine from August 2020. The current risk level was graded as 'very high' and control measures were highlighted including the fact e-learning could be accessed by staff from home and line managers could view training compliance at any time. Matrons were identifying staff who were not compliant and providing the option for staff to be paid overtime to complete training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff knew how to recognise and report abuse. However, not all staff were up to date with safeguarding training at the required level.

Medical and nursing staff completed training specific for their role but there were low levels of compliance with level three safeguarding adults' training. For nursing staff in specialised services and medicine divisions, 94% had completed level two safeguarding adults' training with completion rates above the trust target of 90%. However, only 56% of nursing staff in the specialised services division and 64% of nursing staff in the medicine division had completed level three safeguarding adults training.

Medical staff had access to some levels of safeguarding training, but training compliance did not meet the trust target of 90%. For medical staff, compliance with safeguarding adults' level two training was 69% in specialised services division and 67% in the medicine division. Data showed no medical staff had received level 3 safeguarding training. We were told by the trust they were in the final stage of implementing the recommendations of the intercollegiate document 'Adult safeguarding: roles and competencies for health care staff'. The numbers of staff identified as requiring level 3 training had been agreed with other local health providers and the local clinical commissioning group. The trust had identified the risk of not achieving targets of mandatory training compliance, which included safeguarding. We also saw a recorded risk specifically around level three safeguarding training compliance for staff working in the emergency department. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff were able to describe how they supported patients with protected characteristics to provide person centred care.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff told us they felt confident in identifying adults and children at risk and gave examples where referrals had been made to other agencies. We saw safeguarding risks were discussed during handover meetings. For example, we observed a handover meeting where a consultant agreed to follow up a safeguarding referral after concerns were identified.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Nurses we spoke with were aware of safeguarding processes and how to get advice from the trust safeguarding team. Staff told us there were link nurses and the safeguarding team were available and approachable. Forms to complete a safeguarding referral and guidance were accessible to staff. Nursing staff also told us information relating to safeguarding risks were discussed in daily safety briefs.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

From April 2020 to April 2021, the trust reported 31 infection control incidents across all sites. Eight of these incidents (44%) were reported within medicine at the UHBW Bristol main site and related to COVID-19.

Ward areas were visibly clean and had suitable furnishings which were well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We observed all ward areas we visited to be visibly clean and corridors uncluttered. We saw up-to-date cleaning records displayed outside patient rooms and in bays on all wards we visited.

Staff followed infection control principles including the use of personal protective equipment (PPE). All wards we visited had access to hand sanitising gel, and we observed staff regularly washing their hands or using gel. All staff we observed, followed the trust policy of arms being 'bare below the elbow' and wore PPE. We saw clear guidelines on doorways of individual rooms or bays to describe the infection risk within that area and the type of PPE which should be worn. There were good quantities of PPE available, including gloves and aprons. Staff told us there had been shortages of some PPE in March 2020, at the beginning of the COVID-19 pandemic, but these were quickly resolved, and PPE was readily available thereafter.

Staff tested patients for COVID-19 and all patients had a 'COVID-19 passport' at the front of their paper record. This document showed the results of COVID-19 testing on days one, three, seven and 14 in line with trust policy. Staff used a colour-coded system which was used for patient notes, an electronic patient whiteboard system and to label patient isolation rooms. Staff discussed patient's infection status as part of handover meetings.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff used green 'I am clean' stickers to label when equipment had been cleaned. We saw this used in all wards we visited.

Environment and equipment

The design, maintenance and use of facilities and equipment mostly kept people safe. However, the use of premises outside of their intended purpose could compromise patient care and privacy. Staff mostly managed clinical waste well.

The design of the environment followed national guidance in most ward areas. However, the endoscopy unit, based in Queens Day Unit, did not meet the requirements of the Joint Advisory Group on GI endoscopy (JAG). For example, while 'clean' and 'dirty' areas (used for decontamination of equipment) were separated, access to 'dirty' areas was not restricted.

Patients could reach call bells and staff responded quickly when called most of the time. We observed staff responded to calls bells within good time on most wards. However, we did note two occasions where call bells were not answered for over five minutes. We also observed where patients were in 'boarding beds' (an additional bed in a bay used in times of demand) patients did not always have access to call bells. We raised safety concerns about this at the time of the inspection and the trust took action to review all 'boarding beds' and ensure patients had access to call bells.

Staff carried out daily safety checks of specialist equipment. Tamper evident resuscitation trolleys were checked on a daily basis to ensure they were stocked, and items were within their use by date in order to respond to emergencies. We found all checks we reviewed were completed daily. Records showed the name of the member of staff who had checked the equipment, the date and signature.

The service had suitable facilities to meet the needs of patients' families. For example, the stroke unit had a room that patients' families could use. Visiting had been restricted during the COVID-19 pandemic. Some wards had reintroduced visiting in line with government guidelines, this was limited to one nominated visitor at any time within a four bedded bay.

The service mostly had enough suitable equipment to help them to safely care for patients. Physiotherapy staff we spoke with confirmed they had good access to equipment, including when the rehabilitation gym was closed during the COVID-19 pandemic. We were told about a lack of cardiac monitors on specialist wards. The issue had been escalated, was recorded as a risk on the divisional risk register and monitors had been ordered.

We saw equipment was clearly labelled as being ready to use and dates of the next service were noted on the equipment. We checked a number of pieces of equipment throughout the hospital and saw they were within service date.

Staff mostly disposed of clinical waste safely. We saw clinical waste was separated and disposed of safely on most wards we visited. However, we saw clinical bins were left open in some areas. On ward A800 we saw two bottles of urine left unsupervised in a human waste disposal machine for several minutes. This could pose an infection risk.

Substances hazardous to health were not always kept securely. We saw examples where sluice doors were closed but not locked, despite having key code systems to be able to secure them. In one unlocked sluice we saw substances hazardous to health were inside. We found 16 tubs of chlorine releasing disinfectant on a shelf, which had the potential to cause harm if ingested. We raised this safety issue with the trust at the time of the inspection.

The use of the premises could compromise patient care and privacy during times of increased demand. The trust was using additional beds put into bays to accommodate increases in demand. This process was known as 'boarding'. We saw this happening on a number of wards. We were told by the divisional leadership team there were 28 'opportunities' for boarding patients within the hospital site. The division had taken the decision to undertake 'boarding' as a safer option than opening escalation wards, which they were not able to safely staff.

There was a standard operating procedure for ensuring the boarding of patients took place when certain criteria were met. We did not see any inappropriately placed individuals that did not meet these criteria. However, we saw patients with no access to calls bells or electricity on wards A800 and C805 during the inspection. In spaces where there was no access to electricity, beds were not able to be used to their full function.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Patients were monitored and assessed using the National Early Warning Score (NEWS2) 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. A patient whose condition was deteriorating could be identified and their condition escalated for further medical review. We reviewed 36 patient notes and saw all NEWS2 scores were calculated correctly and escalated appropriately to act on any risk of deterioration.

We saw evidence of patients whose condition was deteriorating being escalated for medical review in line with guidance. For example, records we reviewed showed that an individual had been monitored and their oxygen levels rechecked after 20 minutes, after they had scored highly on NEWS2 due to low oxygen saturation levels.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 36 patient records during the inspection. We saw risk assessments were completed for each patient on admission and were reviewed regularly.

Staff told us risk assessments were easy to complete and there was a booklet where risk assessments could be completed.

Staff knew about and dealt with any specific risk issues. Staff told us there was a clear process to follow should a patient experience a fall and reporting incidences of falls was easy to do.

We saw records which clearly showed risk assessments for patients at risk of developing pressure ulcers. With each risk assessment there was a clear care plan of what needed to occur to prevent ulcers from occurring.

Risk assessments were completed to establish the risk of a patient developing a venous thromboembolism (VTE) this was a condition in which a blood clot forms in a vein, most commonly in the deep veins of the legs or pelvis. Since August 2019, the trust had completed VTE risk assessments electronically using a computer system. This ensured risk assessments could be completed in full, timed, dated and signed accurately by the person completing them and could be accessed at any time.

Staffing

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff an induction. However, staff felt pressured and impacted by ward changes.

The service had enough nursing and support staff to keep patients safe. NHS England collects data on a monthly basis to show staffing levels in relation to patient numbers on inpatient wards within hospitals. This is known as the Care Hours Per Patient Per Day (CHPPD) figure. In December 2020, the trust average CHPPD was 10.32, which was better than the England average of 9.1. The average number of CHPPD for registered nurses within medicine was 6.97, which was better than the England average of 5.46.

The service provided us with information regarding their staffing levels. Within medicine the extent of rota hours filled by registered nurses was 98.6%. The service ensured gaps in rotas were filled with additional support staff, which was reflected in the overall combined rate of filled hours of 102%.

Staff told us staffing levels were pressured during the COVID-19 pandemic with staff being moved between wards regularly. The wards ensured a band six nurse worked on all shifts to provide additional support.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. There was a process for reviewing the required numbers and skill mix of staff needed to safely provide patient care. A nationally recognised tool was used by ward managers to assess the acuity of patients and the number of staff required to care for them. We observed a site meeting during the inspection where matrons provided a live update on staffing levels to the divisional directors. This ensured all leaders within the division had a complete picture of staffing pressures throughout the hospital.

The service had low sickness rates. From September 2019 to January 2021, nursing staff within medicine had an average sickness rate of 4%. This was below the England average and trust overall rates. The most reported reason within medicine for sickness was anxiety, stress and cold or flu symptoms.

Medical care (including older people's care)

The service had low vacancy rates but there was an increase in April 2021. Vacancies were low with under 5% vacancies within specialised services and the medicine division. However, vacancy rates had increased to 9% in the medicine division in April 2021.

The service had low turnover rates. The turnover rates in the medicine and specialised services division were 18% and 12% respectively in April 2021.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Agency staff were used less often than bank staff. When using agency staff the trust would attempt to use the same staff so they were familiar with the service. Data showed agency staff usage for both medicine and specialised services between April 2020 and March 2021, was low with 1% usage. Bank staff usage ranged between 8-11% for the medicine division and 3-6% within the specialised services division.

Staff told us their biggest concerns remained staffing levels. Staff told us they had the numbers of staff they needed, but this often meant bringing in staff from other wards and relying on bank or agency staff. Numbers of expected and actual staffing arrangements were on display outside each of the wards we visited. During the inspection, we saw wards were not always staffed as planned but action had been taken to ensure staffing was safe. For example, we saw ward A800 had one registered nurse under their expected staffing level. However, an additional nursing assistant was available and the nurse in charge was available to support. Staff told us this happened on a regular basis and impacted upon the nurse in charge having less time in a supervisory role.

Nursing staff told us they felt able and supported to raise incidents where they felt the staffing levels on wards were not safe.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff an induction.

The service had enough medical staff to keep patients safe. Data showed there were enough medical staff to keep patients safe. At the time of the inspection, there were 413 full time equivalent (FTE) medical staff employed by the medicine and specialised services divisions against a budget of 401. The service was therefore over their established needs by 3%. However, budgeted targets were being reconsidered as trainee doctors had recently joined the medical divisions from within the trust and this had not yet been taken into consideration.

We saw vacancies of medical staff within several areas of the divisions including dermatology (2.9%), cardiology (2.5%) and rheumatology (2.5%). The highest vacancies were within the ‘care of the elderly’ specialities (3.9%).

Leaders monitored where there were gaps within medical staffing and identified areas of risk. There were rolling recruitment campaigns and staff were being supported to develop into roles. For example, advanced care practitioners and physician associates were supporting stroke services where recruitment had been difficult, and levels of medical staffing presented a risk to the service.

Medical staffing was recorded as a risk on divisional risk registers. A recruitment and retention group had been introduced into the governance structure and reported to the divisional workforce committee. This provided oversight and dedicated planning for recruitment and retention.

Medical care (including older people's care)

Managers could access locums when they needed additional medical staff. The agency usage of medical staff was for 2.86 full time equivalent in April 2021.

Sickness rates for medical staff were low. Medical staff had an average sickness rate of 1.1% and rates were consistently lower than the England and trust overall rates.

The service had a consultant on call during evenings and weekends.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care. Some patient identifiable and confidential information was not always stored securely.

Patient notes were comprehensive, and all staff could access them easily. We reviewed 36 sets of patient records and found them all to be up to date and included risk assessments with care plans for risks including manual handling assessments, bedrails and pressure ulcers. Records were stamped by nursing staff to ensure legibility of their name and registration number and then signed. Medical plans were clear, and we saw evidence of observations being taken in line with plans.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff used a computer application which could be accessed on a mobile phone or tablet device to be able to record observations of patients and to raise tasks with other specialisms such as pharmacy or dietitians.

Some patient identifiable and confidential information was not always stored securely. Paper records on wards were kept in locked trolleys or within locked rooms where only staff had access. Mostly staff were observed to be careful to maintain confidentiality of paper records. However, we saw one occasion on ward A524 where a handover sheet with confidential patient information was left unsupervised.

We observed personal information was visible to other patients on ward A400. For example, a whiteboard in front of a nurse station had details about a patients' plan of care, diagnosis and mental health needs. This was raised at the time of the inspection with the matron and the nurse in charge and changes were made to the whiteboard to ensure confidential information was removed.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when prescribing, administering, recording and storing medicines. Medicines advice and supply were available seven days a week. An on-call pharmacist was available outside of core working hours. Staff were well-informed of this and knew the routes to contact pharmacy at all times of the day. Medicines supply was available out of hours by searching a database to identify stock within the hospital or via the pharmacy robot. Nurses used patient group directions to administer some medicines.

Where patients had specific medicines administration needs, these were clearly documented and staff followed protocols to administer medicines safely, for example via a feeding tube.

Medical care (including older people's care)

Patients on wards were supported to self-administer their medicines if a risk assessment showed it was safe for them to do so. Patients waiting to go home in the discharge lounge were encouraged to self-administer medicines to promote independence. A carer or family member could also assist patients to take medicines while waiting to go home. Any medicines administration in the discharge lounge was recorded on patients' prescription charts.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

All patients records we checked had an assessment for venous thromboembolism (VTE) and were prescribed a prophylactic medicine when appropriate. Records for one person showed that pharmacy had asked for a review of VTE prophylaxis the previous day and this had not been actioned by medical staff. We asked the ward pharmacist and they said the person was not being discharged with this medicine, so review was not urgent.

Staff provided counselling to patients and/or their carers to explain changes in medicines or when new medicines were started. Patients were provided with summaries of their medicines at discharge that showed all changes, new medicines and dates when any current medicines should be stopped.

Staff provided support to patients to inform them about their medicines, allow them to raise concerns and ask questions. Staff took account of patients' personal, cultural and religious needs. People were supported to continue taking over the counter or complementary medicines if they were safe to do so.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. On the wards, medicines were stored in dedicated secure storage areas with access restricted to authorised staff. Medicine trolleys and patient's bedside lockers were also used. We checked storage arrangements on four wards we visited and found medicines, including emergency medicines, were stored safely and securely.

Prescription stationary was stored securely, and its use tracked appropriately.

Antibiotic audits demonstrated that the trust was mainly compliant with prescribing in line with national and local guidance. However, the reason for prescribing an antibiotic was not always recorded on prescription charts.

Staff followed current national practice to check patients had the correct medicines. We looked at electronic medicine records for 14 patients in the hospital. Medicines reconciliation was initiated in the emergency department by a pharmacist prescriber and completed within the medical admissions unit. We identified one prescription for an antibiotic where the clerking proforma said the patient was allergic to this group of antibiotics. We highlighted this to the ward pharmacist who checked previous admission records and spoke with the patient. A recording error had been made on the clerking proforma and the pharmacist amended this record, but this had not been identified prior to prescribing the antibiotic.

Pharmacists in the medical assessment units joined the multi-disciplinary team meetings to ensure they were aware of patients taking high risk medicines.

Medicines issues that might affect discharge were identified early, for example people who would need a medicines compliance aid at discharge. This improved the flow of patients through the hospital, medicines were dispensed at the time of discharge and therefore delays to discharge were proactively minimised.

Medical care (including older people's care)

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The trust acted rapidly to ensure patients were kept safe considering alerts or highlighted risks. The Medicines Safety Officer ensured that procedures were amended in line with any National Patient Safety Agency alerts and changes in guidance.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. We did not see any patients being given medicines hidden in food or drink (covert administration), however, staff could explain the requirements of the Mental Capacity Act (2005) and how patients would be assessed, and best interest decisions made. Pharmacy advice was available to make sure if medicines were given covertly, they were safe and would be effective.

When a medicine was administered to manage agitation or aggression (rapid tranquilisation), a policy was in place to enable medicines to be appropriately prescribed and monitored. Staff we spoke with understood the requirements within the policy.

We reviewed the records of some patients living with dementia, or people with a learning disability. No patients were prescribed psychotropic medicines to control their behaviour.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. All staff we spoke with told us there was a strong learning culture and staff were actively encouraged to report incidents in order to support learning and improvement. There was an application on the desktop computers to allow for staff to report incidents quickly and in a timely way.

Staff raised concerns and reported incidents including serious incidents and near misses in line with trust policy. Between 1 January 2020 to 12 May 2021 the most reported incidents for medicine were patient accidents (16%), 7% more than reported trust wide. For the same period implementation of care and ongoing monitoring / review (15%) and medication incidents (12%) were the second and third most reported incidents within medicine. Percentages remained similar to the corresponding period in 2019/20. Most incidents over this period were reported to have caused no harm (76%) or were classified as low harm incidents (21%).

The Serious Incident Framework, 2015 stated that an incident should be considered as a serious incident (SI) if a patient's death was unexpected or avoidable which was contributed to or caused by weakness in care or service delivery. From April 2020 to April 2021, the UHBW Bristol Main Site location reported 18 serious incidents within medicine**.** The most reported incidents at Bristol Royal infirmary were health care associated infections or infection control incidents meeting SI criteria, eight incidents 44% of all incidents reported for this site , pressure ulcer meeting SI criteria, five incidents (28%) and slips/trips/falls meeting SI criteria four incidents (22%).

From January 2021 to June 2021, the trust reported zero never events in specialised services or medicine divisions at UHBW Bristol main site. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them.

Medical care (including older people's care)

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff we spoke with demonstrated a clear understanding of the duty of candour and discussed how they would be open and honest with patients. 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 met to discuss the feedback and look at improvements to patient care. Staff we spoke with told us learning from incidents was discussed at morning 'safety huddle' meetings and details of learning shared across the trust through emails and debriefs. For example, infection prevention and control leads for both the medicine and specialised services divisions told us there had been some lapses in infection control practices that were highlighted through incident reporting. The leads went back to staff to discuss feedback around this and engaged staff with teaching sessions and quick access guidance. Practice was seen to improve as a result.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. The trust had an incident reporting policy which outlined the roles and responsibilities of those investigating incidents. We viewed meeting minutes where incidents were discussed, and actions taken to share learning.

Managers debriefed and supported staff after any serious incident. We were told of situations where support was offered for staff to debrief after a patient death with emotional and occupational health support provided. Managers provided emails to members of staff who had raised concerns outlining a response and actions taken.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The service continually monitored safety performance. The service audited the prevalence of patient harms such as pressure ulcers and falls to analyse and monitor their performance. We saw the service used a healthcare governance application to carry out safety audits on wards in order to monitor their performance. A quick response (QR) code was displayed at the entrance of wards we visited. Patients, staff and visitors could use any smart device such as a tablet or mobile telephone to access the results.

Staff used this information to improve services. We saw the trust held a performance dashboard, which enabled each division to report their audit and quality information on a monthly basis.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Medical care (including older people's care)

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies, care and treatment pathways, and clinical protocols had been developed in line with national best practice recommendations. These included the National Institute for Health and Care Excellence (NICE) guidelines and quality standards.

Policies were available to all staff on the trust intranet system and staff demonstrated they knew how to access them.

The trust conducted audits to ensure NICE guidelines and quality standards were being followed including:

- CG103: Delirium: prevention, diagnosis and management
- CG161: Falls in older people: assessing risk and prevention
- CG184: Gastro-oesophageal reflux disease and dyspepsia in adults: investigation and management
- NG89: Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients told us food was of a good quality. One patient told us food choices were available, meals were “well cooked and nicely presented”. Housekeeping staff on one ward told us they had been working with dietitians in the trust who usually work with patients with a cancer diagnosis whose sense of taste had been affected by treatment. They used this information to provide snacks for patients who had lost their taste due to COVID-19. They provided salty crisps, milkshakes and smoothies to support those affected, to eat and drink.

We observed nursing teams supporting housekeeping staff to provide meals and food was served hot. Mealtimes were ‘protected’, so visiting times were at a different time to food being served to encourage people to eat in a calm environment without distraction.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. A malnutrition universal screening tool (MUST) was used by the trust to determine individual hydration and nutritional risks. This was completed on admission and once a week thereafter. We saw clear information on diet types were maintained on patient doorways and whiteboards. Where patients were not eating or drinking well, we saw fluid and food charts were being used.

Staff fully and accurately completed patients’ fluid and nutrition charts where needed. We reviewed 36 patient records and saw fluid and nutrition charts completed accurately including where specialist feeding, and hydration techniques were needed. In records we viewed we noted there were times where no running total of fluids was added. While not unsafe, this meant more time was needed for staff to determine input and output.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Staff told us specialists could be referred to easily through the trust computer systems. We saw documentation completed by dietitians who had prescribed a clear dietary regimen. The name and registration number of the dietitian were clear and legible.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. A nationally recognised tool was used to assess patients' pain. In addition to this, the Abbey Pain score was used for patients who were unable to communicate their experience of pain verbally. The tool was based on using facial expressions and body language to determine pain levels. We saw staff making observations and completing pain assessments regularly on all wards we visited.

Patients received pain relief soon after requesting it. Patients told us and we observed staff on all wards asking about levels of pain and assessing patient comfort levels. Patients told us they received medication promptly and were not left in pain.

Staff prescribed, administered and recorded pain relief accurately. Staff discussed patients pain management needs during handovers to ensure pain was managed appropriately. We reviewed 14 patients' medical records and found pain relief to be appropriately prescribed and recorded accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under some relevant clinical accreditation schemes but had not achieved the standards for endoscopy services to be accredited by the Joint Advisory Committee.

The service participated in relevant national clinical audits. The National Clinical Audit & Patient Outcome Programme (NCAPOP) was mostly suspended during periods of the COVID-19 pandemic. Members of the trust clinical audit and effectiveness team were re-deployed to support other key services. Due to the challenges of the pandemic, audit work had been limited in 2020 and the team were starting to resubmit audits to establish their latest benchmarks at the time of inspection.

The trust had purchased a new project management system to manage and track audits. There were plans to streamline processes for assurance against national guidance. The system commenced in May 2021.

The service was able to benchmark against the following national audits, and performance in most audits was in line or above national averages:

- Myocardial Ischaemia National Audit programme published in July 2020, showed the hospital was meeting the national standard for proportion of patients receiving all appropriate secondary prevention medications and for the rate of referral to a cardiac rehabilitation programme after discharge.
- The Heart Failure Audit published in July 2019, showed the numbers of inpatients admitted with heart failure who received input from the specialist team and those discharged with medicines for their condition was better than the national average. However, the number of patients who received cardiology follow up was worse than the national average.
- The National Prostate Cancer Audit published in March 2021, showed the percentage of patients experiencing a severe gastrointestinal complication requiring an intervention following radiotherapy was within the expected range.

- The National Bowel Cancer Audit, published in December 2020, showed indicators were in line with expected levels. The post-operative length of stay (more than five days) after a major resection was favourably comparable (63%) with the national aggregate (62%). The National Lung Cancer Audit published in September 2019, showed four indicators were within the expected range. However, the proportion of patients seen by a cancer nurse specialist (83%) was below and therefore worse than the national standard of 90%.
- Stroke services submitted data to the Sentinel Stroke National Audit Programme (SSNAP) 2019 audit and had a score of B overall. We spoke with the consultant stroke lead for the service and were told the data showed there was progress to be made with direct admission to stroke services within four hours and seven day working. Improvement work was ongoing.

The Bristol Haematology Centre was accredited by the Joint Accreditation Committee of the International Society for Cellular Therapy and the *European* Group for Blood and Marrow Transplantation. This was Europe's only official accreditation body in the field of stem cell transplantation and cellular therapy. It promoted high quality patient care and medical and laboratory practice through a voluntary accreditation scheme.

The endoscopy service was not accredited by the Joint Advisory Group (JAG) at the last visit in 2019. The main challenges related to the environment. The service needed to continue to work towards JAG accreditation and completed twice yearly submissions to JAG and completed the necessary audits.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Audits were completed which fed into a divisional dashboard to provide assurance to the trust board.

Competent staff

The service mostly made sure staff were competent for their roles. Managers did not always provide an appraisal of their staff's work performance. Staff did feel supported in opportunities to develop.

Managers gave most new staff an induction, but the content and length of induction programmes had been impacted by the COVID-19 pandemic. Medical staff did not always receive an induction, with a 74% completion rate in both medicine and specialised services divisions. We saw this was rated by the division as being below their expected threshold.

Data showed nursing staff in both the specialised services and medical divisions received an induction, with 100% compliance in medicine and 91% compliance in specialised services. This was above the trust expected threshold.

We heard concerns from staff regarding induction for new starters, in particular for health care assistants. We were told during the COVID-19 pandemic the induction process had been reduced with time restraints impacting upon the ability of new staff being able to ask questions. This could impact upon patient safety, as staff may not be fully prepared for their role. However, we spoke with one member of staff who had recently started working for the trust who was positive about the support they had received during their induction period. Managers of the endoscopy service had worked to improve their induction training programme by organising competencies into three stages for staff to work through.

Staff did not always receive regular appraisal by their managers. Appraisal rates for nursing staff in both divisions did not meet the trust target. Appraisals had been impacted by the increased demands of the COVID-19 pandemic. NHS England had provided guidance to NHS trusts to pause appraisals between January 2020 to July 2020, and between 5 November 2020 to 25 March 2021 in order to respond to the pandemic.

Medical care (including older people's care)

During the period May 2020 to April 2021, appraisal rates for non-consultant staff in the specialised services division varied between 72-82%. In the medical division appraisal rates for non-consultant staff varied between 52-57%, which was significantly below the trust target. Nurses we spoke with were positive about the appraisal process and told us they were also able to discuss training needs outside of the formal, annual appraisal.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. We were told about the trainee nursing associate role where band three staff were supported to reach band four, and from there had the option to receive training to become registered nurses. Staff told us this was a good initiative which boosted morale.

The trust employed practice education facilitators to support staff to continue to learn within their own divisions and services. We saw there were practice educators in cardiology, respiratory and endoscopy services. These individuals supported new starters and provided bedside training.

Medical staff were positive about the support they were given to develop and learn. Medical staff told us they felt very well supported in both their training and non-training roles. Consultants were available and gave opportunities for speciality learning and mentoring.

Doctors in training (trainees) told us there was a good mix of registrar and consultant led teaching sessions. All trainees were allocated a named educational and clinical supervisor. Trainees were informed of this allocation at the start of their placement and retained their educational supervisor throughout the placement. A clinical supervisor was assigned each time they moved to a new speciality within the placement.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Nursing, medical and therapy staff worked together well and were all involved in the support and treatment of patients to improve their care. We observed board rounds throughout the service, which included discussions amongst members of the whole multidisciplinary team to support patients. For example, during a meeting we saw discussion around a patient who was awaiting discharge, where an occupational therapist gave updates on equipment needs as well as discussion of another patient where there were safeguarding concerns to be considered.

Staff worked across health care disciplines and with other agencies when required to care for patients. However, there were concerns about access to social work support. We saw evidence of multidisciplinary working throughout the inspection. Care records we reviewed demonstrated clear management plans by medical staff as well as involvement from the wider multidisciplinary team. We observed conversations taking place on wards between diabetes nurse specialists, pharmacists and psychiatric liaison staff.

Staff told us they worked well across disciplines and all staff were “open, helpful, and patient focused”. Staff on the haematology ward told us multidisciplinary working was “exceptional”, communication was good and patient care needs were escalated in good time.

Staff raised concerns about a lack of social work presence on the wards. In response to the COVID-19 pandemic, the local authority had made the decision for social work staff to not attend the wards. This had increased the workload of nursing and therapy staff and impacted upon patient discharge. There was a worry this could impact upon outcomes for older people in particular.

Staff referred patients for mental health assessments when they showed signs of mental ill health. The psychiatric liaison team could be accessed by ward staff. Drug specialist nurses also supported with discharge planning for patients with substance misuse issues. This specialist nurse team of four nurses worked across the hospital, Monday to Friday.

Seven-day services

Key services were not always available seven days a week to support timely patient care.

Consultants led daily ward rounds on acute wards. Patients were reviewed by relevant consultants depending on the care pathway. All patients had a clinical assessment once admitted by a consultant or registrar. This was undertaken within 12 hours.

We observed board rounds on a number of wards, which took place at 9am each morning. We saw consultants, doctors, therapists and nursing staff were all in attendance. We saw discharge plans being discussed with clear plans and members of the team were able to communicate freely.

Patients who were not being cared for on the correct speciality ward for their presenting complaint (known as outliers) were seen by a consultant from the outlier team. This team tracked patients using the trust computer system and visited these patients as a matter of priority wherever they were within the hospital. We visited these patients at the time of the inspection and found they were reviewed by the outlier team in a timely manner.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests but these were not always available 24 hours a day, seven days a week. Therapy services on respiratory wards were available on-site Monday to Friday and were on call over the weekends.

Medicines advice and supply were available seven days a week. An on-call pharmacist was available outside of core working hours.

The endoscopy service provided an out of hours response for patients who may experience a medical emergency overnight or at the weekend.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards. Staff provided health promotion information for patients on all wards we visited. For example, on the haematology and oncology wards we saw information about lifestyle changes as well as infection control in light of COVID-19.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff assessed each patient when admitted and reviewed aspects of health that created risks and looked at what support was available. Patients had access to a drug and alcohol specialist team where patients that were reliant on alcohol or other substances were supported to safely withdraw, using a symptom trigger chart. Medicines prescribed to support withdrawal were reviewed by a pharmacist.

Medical care (including older people's care)

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limited patients' liberty appropriately.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. The trust had policies regarding consent, assessment of mental capacity and the use of deprivation of liberty safeguards. Staff told us they were aware of these policies, and we saw evidence of completed mental capacity assessments in care records we reviewed.

We saw patients were given the opportunity to ask questions about their care, staff assessed their understanding and supported patients to make informed decisions about their care.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Nursing staff knew their responsibilities in terms of what action should be taken if a person did not have the capacity to make decisions about their care. Staff were aware of the need to make a written record of mental capacity assessments and to make best interest decisions in line with legislation.

There was a frustration that the local authority would only accept mental capacity assessments and applications for the authorisation of deprivation of liberty safeguards from medical staff. This was not in line with the Mental Capacity Act 2005 and nursing staff were often better placed to undertake these assessments. We were told this had potential to delay applications and increased workload for medical staff.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, mostly respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Patients we spoke with told us they felt well looked after and call bells were responded to promptly. One patient told us they could "not fault" the care staff who were all "very helpful" and they were "treated with respect".

Patients said staff treated them well and with kindness. We observed a patient being discharged who was very grateful and clearly had developed a good relationship with those caring for them. A number of nursing staff came to wish the individual well and this appeared to be a genuine and positive interaction.

Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed a health care assistant ask if they could check an individual's blood pressure and explained to them what they would be doing. They also used this time to speak with the patient about any pain or discomfort they may be experiencing.

Staff followed policy to keep patient care and treatment confidential most of the time. During the inspection we saw staff lowering their voices and using curtains to maintain confidentiality when providing patient care. However, we saw patients using an additional bed added to a bay were not always afforded privacy. We saw a conversation between a patient and a medical staff member, which could be overheard by other patients due to the lack of space. There were also no privacy screens used around the bed at the time of the conversation. We were told by staff temporary privacy screens were usually available.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. During the inspection we observed a patient waiting to have a procedure. We saw staff providing reassurance, talking with them and keeping them updated on what would be happening.

We saw numerous examples of staff providing reassurance to patients who may need additional support. For example, walking with patients who may have mental health needs to ensure their safety and minimise any distress.

All staff we spoke with were aware of Enhanced Care Observations to provide one-to-one support for those people with complex needs. Staff saw the benefit of having this support, in terms of being able to monitor and understand an individual's behaviour to be better able to provide individualised care.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed board rounds on a number of different wards and saw staff discussed the entirety of the needs of patients including physical, social and emotional. We heard from staff how the emotional needs of older people in particular were being considered and the impact of bed moves on their recovery was well understood.

The trust had a department of spiritual and pastoral care where people of all faiths, or none, could access spiritual support from members of a team who covered a range of religious faiths and traditions. The team provided a 24-hour service in conjunction with two local NHS trusts. There were a number of multi-faith 'sanctuaries' on the Bristol main site where people could access a quiet space for contemplation or prayer. These were based in the Haematology and Oncology centre and Bristol Royal Infirmary hospital.

Staff were conscious of the impact of visiting restrictions on patient's wellbeing. Staff were aware of the need to make exceptions, for example patients at the end of their life or with additional needs. Staff supported patients to speak with relatives over the telephone and were glad to receive more visitors when restrictions had been lifted.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff told us they had dealt with very difficult situations during the COVID-19 pandemic and they had developed increased empathy with patients. Several staff had contracted COVID-19 and understood patient's experiences and anxieties.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff talked about patients compassionately and with knowledge of their circumstances and those of their families. A patient told us they felt well looked after and their needs were fully met, with additional support provided for eating and showering.

Medical care (including older people's care)

Staff told us they supported families who were unable to visit during the COVID-19 pandemic. This was especially difficult for those patients reaching the end of their life where families were unable to be with them. Staff were compassionate and provided emotional support and reassurance they would care for patients in the absence of family or friends.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients told us there were clear plans for their care and staff kept them informed about any changes. We saw a nurse explaining to a patient why and how a dressing change to a wound would be provided and gave the patient the opportunity and time to ask questions. We also saw on numerous occasions nursing staff contacting families to give updates on their relative's progress. For example, we saw a health care assistant giving a detailed update on a patient's condition and well-being to a family member over the telephone in a polite and friendly manner.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff were aware of the types of communication aids that could be used to support patients. Staff were clear about how to access interpreting services and where to go for additional support if needed. Patients told us staff were clear when speaking with them and they could understand what care and treatment was being provided.

Staff supported patients to make informed decisions about their care. We saw a patient being supported in their choice of treatment. The individual was provided with information about the types of treatment available and why a certain treatment would be beneficial. On being given this information they made the decision to refuse treatment. They told us they felt supported in their ability to make this decision and their wishes were respected.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The trust used a national patient survey run by NHS England called the Friends and Family Test, to gather feedback on the service. The national survey was paused in February 2020 due to the COVID-19 pandemic but relaunched on 1 December 2020. From December 2020 to May 2021, the medicine division had received 1862 responses. The results were positive with a high percentage (95.8%) of those asked stating they would recommend the hospital.

The trust also carried out their own patient experience survey. The service asked patients for their feedback on the kindness and understanding showed by staff and scored positively between 92-99%.

Patients gave positive feedback about the service. All patients we spoke with were positive about the service they had received. One patient told us their care had been "excellent" and another that the nurses and doctors had been "very professional" and their experience had been "great".

We saw a number of wards displaying thank you cards on their walls. We saw personal messages of thanks from patients who felt they had received good care. One read "you all do such an incredible job. You are all amazing".

Is the service responsive?

Good 

Medical care (including older people's care)

Our rating of responsive stayed the same. We rated it as good.

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. Managers worked with the wider health care system to plan care and deliver services. The clinical site team held daily meetings with the clinical commissioning group, a local ambulance trust and a local acute hospital trust within the area to understand demand and to request or offer mutual aid.

The stroke service consultant lead was working closely with local commissioners and the wider system. There was a public consultation on the future of hospital-based stroke services at the time of inspection. The stroke service consultant lead was positive about providing timely access to stroke services at the hospital. They felt they had the support from the trust board.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. We saw patients were cared for in either female of male bays wherever possible. There were some areas, when used in escalation, that did not allow for this. For example, in times of increased demand the endoscopy unit was used as an escalation area to provide beds for patients. Despite having access to separate toilet facilities at either end of the ward, the ward could not be guaranteed to provide single sex accommodation. The service reported when this area was required and when a mixed sex breach occurred. This was not in use at the time of the inspection.

Facilities and premises were mostly appropriate for the services being delivered. Most ward areas we observed were appropriate for the care being provided. They had adequate space and access to equipment. However, the hospital was challenged in terms of the size of the building, to meet the demand for services. As a result, some services were delivered in areas outside of their intended use. For example, patients who were cared for in an additional bed (boarding), did not always have access to electricity or calls bells. Privacy was impacted and should a patient require urgent treatment some bays were not large enough to accommodate emergency equipment.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health needs, learning disabilities and dementia. There were arrangements for staff to access urgent mental health support. Staff told us they knew how to request services and there was not an issue with accessing these in a timely manner.

The service relieved pressure on other departments when they could treat patients in a day. We saw initiatives within specialities to support patients who could be safely discharged from the service. Cardiology leads told us there were plans for suitable patients to be discharged within 24 hours with remote rehabilitation support. The frailty team included a consultant, nurses and a pharmacist to support older people to prevent admission or support timely discharge wherever possible.

The service had systems to help care for patients in need of additional support or specialist intervention. Specialist nurses were available to ensure additional support or intervention was provided. For example, we saw diabetes and substance misuse specialist nurses being accessed for support and present on wards we visited.

Meeting people’s individual needs

Medical care (including older people's care)

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health needs, learning disabilities and dementia, received the necessary care. Staff completed dementia care training during their induction to the service. Staff we spoke with, especially on speciality wards caring for older people, were understanding of the needs of patients living with dementia. We saw boards with resources for staff and patients to support good practice in working with those living with dementia. For example, an emphasis on getting patients dressed and out of their pyjamas to mentally prepare people for discharge.

We saw a gastroenterology ward which was a dedicated 'young person friendly ward'. The adaptations to the ward had come about through a piece of work around transitions with the children's hospital for young people aged 16-17. This ward supported younger adults with eating disorders or mental health needs and recognised the unique support these individuals required.

Wards were designed to meet the needs of patients living with dementia. We observed clear signage throughout patient areas on wards. For example, pictures as well as words being used to show where toilets were located.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff told us they were able to access translation services easily. Staff were able to give examples of where they had requested clear masks to be able to communicate effectively with people who relied upon lip reading. Staff in the discharge lounge described how they supported patients who may need translation services or other reasonable adjustments to support communication, including providing advice on medicines.

The service had information available in languages spoken by the patients and local community. Patients had access to information in a language they understood. Information was available on the trust website in several languages used by the local community.

Staff supported patients living with a learning disability by using patient passports. We reviewed 36 records and found examples of hospital passports being used for people with a learning disability, to support their care when an inpatient. One record showed a person with a learning disability was referred to the trust's learning disability and autism team within 48 hours of admission. The hospital passport for this patient identified their communication and support needs. It also documented their need to be supported to take their medicines by a close family member whom they trusted. This allowed staff to be aware of individual needs and ensure care was personalised.

Access and flow

People could access the service when they needed it and received the right care promptly. The percentage of people receiving treatment within 18 weeks from the time of referral was mostly above and therefore better than the national average.

Managers and staff worked to make sure patients did not stay longer than they needed to, but delays did occur. From February 2020 to January 2021, the average length of stay for medical elective patients at Bristol Royal Infirmary was 4.5 days, which was lower than the England average of 6.7 days. For medical non-elective patients, the average length of stay was 6.9 days, which was higher than the England average of 5.9 days.

Patients in cardiology stayed on average 1.3 days longer compared to the England average. General medicine had a longer length of stay compared to the England average, by 1.2 days.

Medical care (including older people's care)

Some patients stayed longer than needed despite work being undertaken to reduce lengths of stays. For example, from April 2020 to March 2021, there was a loss of 644 bed days to the trust in medicine and a further 104 bed days lost in the specialised services division where patients had experienced a delayed discharge from hospital. This created days when beds were not available for patients coming into the hospital.

In response to the COVID-19 pandemic, social work staff from the local authority were no longer present on the wards. Staff felt this impacted upon their workload and ability to discharge patients in a timely way to the most suitable care.

We observed discharge planning was discussed during handover meetings and the discharge lounge was well used. Staff from the lounge visited wards to support the discharge of patients every morning.

Staff tried to avoid moving patients between wards at night, but this did occur in times of increased demand. Staff told us they were aware this was against trust policy and reported when this did occur as an incident so it could be monitored. We were told of examples within the last month where patients who were living with dementia had been moved late at night.

Managers worked to keep the number of cancelled treatments to a minimum. Data showed operations cancelled by the hospital at the last minute occurred in less than 1% of cases.

Managers made sure they had arrangements for medical staff to review any medical outlier patients. An ‘outlier’ team made up of medical staff including consultants, were responsible for reviewing medical patients who were being cared for on non-medical wards. Patients were ‘tracked’ on the trust computer system to make it clear where an individual was in an outlying bed. We visited patients who were identified as being cared for on non-medical wards and saw they had all been reviewed promptly by medical staff.

Managers worked to minimise the number of medical patients on non-medical wards. During the inspection we saw there were 16 patients across the trust in an outlying bed and five patients were ‘boarding’ (an additional bed used in a bay).

A clinical site team managed flow throughout the hospital and met regularly during the day to ensure oversight of patient numbers and staffing levels. The clinical site team also liaised with a local trust, ambulance service as well as the local clinical commissioning group on a daily basis, to monitor demand and gain support from the wider healthcare system.

The trust had an escalation policy and a number of standard operating procedures to support safety at times of high demand. We saw standard operating procedures were clear that patients in boarding beds or on escalation wards, should have access to specific equipment and not stay in those beds for longer than 48 hours. However, we saw patients who had been in these beds for up to five days, which was not in line with procedure.

Staff noted they felt escalation and the use of additional beds had become “the norm” and the procedures needed to be reviewed to ensure demand was managed safely.

During the COVID-19 pandemic many wards were repurposed to manage demand on the service. In particular this had led to the loss of a dedicated admission area for the care of older patients. Care of the elderly beds had also been reduced to 58 from 75 beds. Staff were aware this may lead to increased lengths of stay for people due to the likelihood of bed moves and increased delirium impacting upon discharge. Divisional leaders were aware of these risks and were in the process of developing a business case to request the reinstatement of a dedicated area.

Medical care (including older people's care)

The percentage of people receiving treatment within 18 weeks from the time of referral were mostly above and therefore better than the national average. From March 2020 to February 2021, four specialties were above the England average for admitted referral to treatment time (percentage within 18 weeks). These were; general medicine, rheumatology, thoracic medicine, gastroenterology and dermatology. One specialty, cardiology, was below (47.8%) and therefore worse than the England average (68.6%). Waiting times nationally had been affected by the COVID-19 pandemic.

The number of patients waiting longer than 52 weeks for treatment increased from April 2020 to March 2021. Cardiology and gastroenterology had the highest numbers of patients waiting for treatment.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Patients told us they felt safe and able to raise any issues with staff on wards.

The service clearly displayed information about how to raise a concern in patient areas. Information about making complaints was available in all areas we visited. We saw posters were available in all departments. The trust website had links to information about how to resolve concerns and how to make a complaint. Patients could use an online enquiry form, email, telephone or in writing. However, the face-to-face 'drop in' service was stopped in line with COVID-19 restrictions.

Staff understood the policy on complaints and knew how to handle them. There were policies and processes to appropriately investigate, monitor and evaluate patient's complaints.

Managers investigated complaints and identified themes. The service monitored complaints and identified themes. From May 2020 to April 2021 across the medicine division there had been 385 complaints, of which 120 were formal complaints. Of those formal complaints 58.5% were responded to within the trust timeframe. 4% of patients who had complained were dissatisfied with the response. Within specialised services there was 190 complaints of which 40 were formal complaints. Of those formal complaints 82% were responded to within trust timeframe. 6.38% of patients who had complained were dissatisfied with the response.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff were able to explain the complaints process and told us they would look to support patients to raise a complaint formally if they were unable to resolve the situation in the first instance.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff told us feedback was given to them regarding any complaints in daily huddles. We saw examples where complaints had been used to inform training and a poster developed to support learning.

Is the service well-led?

Good ➔➔

Medical care (including older people's care)

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. Not all staff felt the executive team were visible.

The medicine and specialised services divisions were led by a divisional director, a deputy director, a clinical chair, a head of nursing, a lead allied health professional and clinical directors. All posts in each divisional triumvirate (divisional director, clinical chair and head of nursing) were filled and leaders had the skills and abilities to run the service.

Staff told us they received strong leadership from their direct managers, matrons, ward managers and the heads of nursing. Nursing staff told us matrons had based themselves on wards to provide additional support to staff, which was appreciated.

Medical staff felt divisional directors were approachable and supportive. The directors told us they were not as visible across the service during the COVID-19 pandemic as they would have liked, due to competing demands. They had reflected on this and recognised where improvements could be made. Leaders were aware of the challenges facing their services. For example, the loss of beds for older people, in particular the specialist unit being repurposed in response to the pandemic, staffing levels and the challenge to integrate with Weston hospital as part of the recent merger.

Staff told us they received weekly emails from the chief executive but did not feel the executive team were visible. This was particularly felt on wards where there had been changes in response to COVID-19. Staff felt managers “did the best they could” but the situation had been very difficult.

Leaders spoke positively about their staff and told us they recognised the incredible efforts they had made across the trust during the COVID-19 pandemic.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action.

Divisional leaders told us the merger with Weston hospital went ahead in April 2020 but the plans to integrate services had been significantly impacted by the COVID-19 pandemic. Plans were put on hold to allow efforts to be focused on the response to the pandemic and integration had not happened as quickly as desired.

Staff told us they had not been impacted by the merger with Weston Hospital. Some staff were not aware a merger had taken place.

All staff were aware of the trust values and told us those values were meaningful for them. We saw the trust values were highlighted on posters and information boards throughout the trust. These were respect everyone, embracing change, success and working together. Staff felt the trust upheld these values.

In May 2021 divisional leads had launched a strategy to improve patient flow and to support staff to become involved through consistent quality improvement methods to support safe and timely patient care.

Medical care (including older people's care)

Culture

Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care. While staff knew how to raise concerns without fear, they were not confident that changes would always be made as a result.

Managers encouraged learning and a culture of openness and transparency. Senior staff agreed that staff or teams would speak up to them when they needed to and would be heard. Staff said they were encouraged to speak up and felt comfortable about raising any concerns. Staff were also aware they could raise concerns about patient care and safety, or any other anxieties they had with the Freedom to Speak Up Guardian. However, not all staff thought that it was worth speaking to the Freedom to Speak Up Guardian as they were not confident this would lead to change.

Staff told us they were well supported by their immediate managers and matrons and were able to raise issues. However, they felt less supported by the executive team and the trust. Staff told us they often experienced low morale as they were not able to provide the level of care they wanted for patients in times of increased pressure. Staff were not convinced the executive team understood the challenges they faced or respected their efforts.

Staff described the months during the COVID-19 pandemic as “horrific”. Staff told us they felt exhausted. Excellent teamworking and support from colleagues were the main reasons they were able to continue. Staff told us they were supported in terms of their wellbeing and debriefs were encouraged by direct managers.

The divisional leadership teams from both divisions recognised the need for staff to be supported to maintain their wellbeing. At the beginning of the pandemic, counselling was available, but the team were aware that wellbeing initiatives needed to be brought to staff on the wards, as there was pressure on time. A wellbeing lead and wellbeing representatives were introduced, and champions were identified on each ward to support staff where it was needed. We saw wellbeing noticeboards were located near staff rooms and posters with quick response barcodes, which staff could scan to access several wellbeing resources.

We heard of positive examples where staff were supported in their own wellbeing. These included debriefs following the death of a patient and staff being supported well if they needed time off or a phased return to work.

We saw staff on ward A400 and A413 were nominated for the “star of the ward” awards. Staff were provided with gifts as a boost to morale.

Staff were passionate about providing the best care to patients. They described how good care could be achieved through care planning and effective risk assessments and were aware of their responsibilities and roles.

Governance

Leaders operated effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities and in most areas had regular opportunities to meet, discuss and learn from the performance of the service.

There was a clear performance management reporting structure with monthly governance meetings looking at operational performance. This included a review of incidents reported, complaints, staffing, audit status, infection control, risks identified on the risk register and risk management, and education and training.

There was a governance framework and monthly meetings held within each speciality service. These then fed into the divisional quality and patient safety committee, which was held once a month. From this meeting, risks would be escalated to the trust level quality, safety and risk management boards.

We reviewed the divisional level quality and patient safety committee meeting minutes from February to April 2021. Three meetings had been held in that time and the minutes provided a sufficient level of detail to document the conversations that had taken place and the decisions made.

Quality and patient safety committee meetings were well attended by individuals with the appropriate level of seniority for decisions to be made. There was a standard agenda, which ensured discussion of clinical incidents and patient experience, as well as assurance reports from specialities within the divisions.

Not all staff were able to attend team meetings on wards due to time constraints. We were told by a number of staff on different wards there were no formal team meetings held due to time restrictions. Communication folders were used by managers to relay key messages and staff did attend a daily huddle to be able to discuss patient safety issues.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

The trust had systems for identifying risks and plans to eliminate or reduce them. However, in some circumstance's risks had been identified without sufficient mitigation for long periods of time.

The medicine and specialised services divisions each held a risk register which clearly identified individual risks, control measures and the actions taken to mitigate them. Risks were graded and monitored at monthly meetings.

The service monitored the effectiveness of care, treatment and performance. The service took part in national and local audits and evidence of improvements or trends were monitored. The trust kept a dashboard to monitor performance data. This data was collated to determine the current performance. This information was presented to the trust board to provide assurance.

Since August 2019, the venous thromboembolism (VTE) risk assessment was completed electronically using a computer system. By moving to this format VTE risk assessments were able to be completed in full with the date, time and person completing them recorded, which could be accessed anywhere. Compliance was measured in real time and presented in different formats. Compliance for completion of these electronic documents in March 2021 was 84%, which was below the trust target. We saw evidence this risk was recorded on the risk register, reviewed and actions were being taken to improve compliance.

Staff felt able to raise issues around risk to their managers. Ward staff told us they were aware of specific risks that had been escalated including cardiac monitors that needed to be replaced. Staff told us they had raised the issue; they knew the issue had been acted upon and identified as a risk on the divisional risk register and had been told monitors had been ordered.

The environment on the endoscopy ward had been recorded as a risk since 2016. The poor environment had led to the loss of the Joint Advisory Accreditation. The plans to upgrade this service were part of a long-term strategic capital programme.

Medical care (including older people's care)

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

During the inspection we saw records were kept securely. Paper records were stored in lockable trolleys or in rooms with restricted access. However, we did see some whiteboards which held patient identifiable information with too much detail about individual health needs in ward areas.

Staff could easily access the trust intranet, which provided all policies and guidelines. Staff were able to tell us how they would make referrals to the safeguarding team or other specialists through the intranet.

Information held in the trust electronic system was used by specialist teams. For example, frailty and therapy teams were able to 'track' patients within the hospital and use this to determine who would benefit from their support rather than have to wait for a referral.

Staff told us patient information was clear and records were easy to use. Electronic systems were used to monitor observations, and this provided 'real time' information. This was visible on electronic whiteboards and triggered a need for escalation for any patients whose medical condition was deteriorating.

Engagement

Leaders and staff actively and openly engaged with patients and staff to plan and manage services. They collaborated with partner organisations to help improve services for patients.

In line with guidance from NHS England, the Friends and Family Test was suspended during the COVID-19 pandemic and formal submission restarted in December 2020. 1862 patients had responded to the survey for medical care services in Bristol. Data from December 2020 to May 2021 showed 95.8% of medical care patients would be likely to recommend the service.

There was an awareness of the need for improved well-being and support for staff. A workplace well-being lead had been appointed and the trust were advertising for a well-being screening nurse to provide additional support to staff.

The clinical site team liaised daily with other local hospitals, ambulance services and clinical commissioning groups, to understand demand in the local area in order to support or request support as needed.

A daily briefing was held on all wards we visited however; some wards did not hold formal team meetings in addition to this. They instead held adhoc, informal meetings and used a communication book kept in staff areas to keep members of the team up to date.

Email updates were sent from the chief executive, but staff did not always have the time to read these and staff felt engagement from the executive team could be improved.

The trust took part in the 2020 NHS staff survey. Results showed the trust scored lower than the England average in relation to themes of "quality of care" and "team working".

Medical care (including older people's care)

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Staff and leaders told us there was a strong commitment to learning and improving services. Staff informed us the pandemic had allowed some positive changes to occur, with new ways of working being developed in a shorter time. There was participation in research trials.

We were told of the following examples of learning and innovation:

- Leaders were introducing a quality improvement approach to improve flow throughout the hospital.
- Practice education facilitators were used within the hospital. The facilitators supported training at the bedside for nursing staff, which included simulation and induction training. The aim of this role was to improve safety and patient care.
- Within cardiology a recovery programme had been developed to allow suitable patients to be discharged from the coronary care unit with 24hours. Patients could be supported to complete rehabilitation programmes in their own home and benchmark their journey with remote support.
- A consultant had set up a cardiac liaison service to enhance the care of older patients in the Bristol Heart Institute. The service was in a six-month pilot at the time of the inspection and a business case was waiting for approval.
- The frailty team were undertaking quality improvement work to determine the impact of frailty assessments on length of stay and outcomes for individuals. The team provided training to medical, nursing and therapy staff to promote an understanding of the needs of older people accessing hospital services.