Weston Area Health NHS Trust

Weston General Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital

Urgent and emergency services	
Medical care (including older people's care)	
Surgery	
Critical care	

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected the emergency department, medical and surgical wards and the critical care provision on the high care unit at Weston General Hospital as a result of concerning information regarding medical staffing which we had received following our inspection in May and June 2015. Our inspection took place on 17 and 18 August 2015.

We spoke with 33 junior doctors (both foundation year one and two), 8 middle grade doctors and registrars and 3 consultants. In addition we attended a divisional feedback session, led by a divisional director and attended by 18 junior doctors. We also spoke with nursing staff and the out of hour's coordinator. We interviewed the chief executive, medical director and director of nursing.

The focus of our inspection was on the medical staffing in the trust and also the support and supervision provided to junior doctors.

The trust is not a foundation trust. At the time of our inspection the trust was subject to a transaction process, in which Taunton and Somerset NHS Foundation Trust was the preferred acquirer. This was at the Trust Development Authority's Gateway 2.

Our key findings were as follows:

- The numbers of consultants and middle grade doctors/registrars employed by the trust required improvement to ensure the sustainability of the service. There were a large number of vacancies in consultant and registrar/middle grade doctor posts within the trust. We saw that shifts were covered through staff undertaking additional shifts and by locums. In addition different approaches to medical staffing rotas had been employed, with consultants "acting down" to provide additional support to junior staff.
- The trust had set up a "sustainability board" with partners and key personnel from other NHS trusts in the locale, to work together to gain additional staffing within the hospital. However, at the time of our inspection no additional consultants or registrars had been engaged through the sustainability board to provide services at the trust. Areas of concern were being highlighted and discussions were underway about how other trusts could provide support. Progress was being made in one particular area.
- The trust was developing "metrics" regarding medical staffing at the time of our inspection in order to provide assurance regarding medical staffing numbers. However, it was not clear how the numbers of doctors which made up the staffing establishment had been determined.
- We found that the trust had taken action following our inspection to improve the induction delivered to junior doctors joining the trust as a result of feedback in the GMC survey of junior doctors in 2015. A new cohort of doctors started work at the trust at the beginning of August 2015. All of the junior doctors we spoke with were positive about the induction they had received. Some told us that it had exceeded their expectations, following information they had received from junior doctors who had been at the trust in the past, others told us that it had been better than that which colleagues had had at other trusts. All reported it being a welcoming and friendly hospital. Formal feedback collected by the trust on the induction was also seen to be positive.
- Junior doctors reported that they felt supported in their role and that they had been encouraged to ask for help and support when required. Some junior doctors said that some locums were more supportive than others.
- Most junior doctors reported that they did not have to undertake tasks that they felt ill prepared or competent to carry out unsupervised. However, one junior doctor described having been told to "just get on" with a legal administrative task which they had not carried out before. Following our inspection the trust undertook an investigation of this incident.
- A new director of medical education had been appointed although they had not started in their role at the time of our inspection. Additional support for the medical director had also been sought and was being finalised at the time of our inspection.

Summary of findings

- We saw there were formal teaching programmes in place for junior doctors across the trust. Cover was provided for junior doctors to attend. One junior doctor in the emergency department described being part time which meant several training sessions fell on their days off. They had raised this with the emergency department rota coordinator and had been told they were looking at ways to address this. The number of junior doctors on the rota in the emergency department also made release for study leave to attend conferences etc. difficult as there was not additional capacity to cover shifts. However, this was not reported in other areas of the hospital.
- Junior doctors told us of examples of where teaching had been provided by consultants and more senior doctors. We observed teaching ongoing during our inspection.
- All core surgical trainee posts had been withdrawn by the Deanery (due to a national reduction in the number of surgical trainees) and this had impacted on the capacity of the remainder of the surgical team. The trust confirmed they were addressing the capacity gaps as part of their ongoing staffing review and revision, and posts had been filled by locums and clinical fellows. Concern was expressed that the middle tier of doctors was being eroded which would remove the bridge between consultants and junior doctors. The shortage of substantive registrars created pressure for the team with staff feeling isolated and unable to pursue training opportunities. The trust told us there would be no change in the number of middle tier doctors and that two substantive registrar posts would be filled in October 2015.
- There were 975 incidents reported between 5 June 2015 and 25 August 2015 relating to the areas of the hospital we inspected. Of these only 6 related to medical staffing.
- The trust had implemented a new hazard reporting telephone line, for junior doctors to report concerns. This had resulted in an increase in reporting of concerns, incidents and hazards by this group of staff. All junior doctors we spoke with were aware of the reporting line.
- There were a large number of patients who were described as medically fit for discharge within the hospital, who were waiting for packages of care within the community. This had an impact on the workloads of junior doctors. An action being taken was to work with partners to reduce the number of patients who were medically fit for discharge within the hospital, through the opening of a new facility. However, although an urgent priority, this had not occurred at the time of our inspection, despite actions from the trust to pursue this.

There were areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Ensure that there are suitable numbers of doctors to ensure that a sustainable service is maintained.

In addition the trust should:

- Continue to work with partners to ensure that patients who are medically fit for discharge are provided with care in an appropriate setting.
- Continue to provide effective support, training and supervision to junior doctors within the trust.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services		Although there were sufficient medical staff deployed to ensure the safety of patients, improvements in the number of medical staff were required to ensure the sustainability of the service in the long term. Several posts within the emergency department were vacant and currently covered by locum staff, both long and short term. Consultant cover was provided from 8am – 11pm. Outside of these hours, consultants were on call from home. Whilst medical staff were described as supportive and approachable, with junior staff able to check any concerns, there were occasions when responses were short due to workload pressures. Induction into the department was described as good. A training program was in place, although release of staff for attendance at training outside of this was difficult.
Medical care (including older people's care)		Although the numbers of medical consultants employed by the trust required improvement to ensure the sustainability of the service, shifts and on-call were covered through additional work undertaken and by locum consultants. We saw that action had been taken since our last inspection to ensure that junior doctors received support and training. Junior doctors reported that they felt supported and had not been in a position where they were required to undertake procedures or activities for which they felt ill prepared, trained or supported to carry out. Feedback on the induction of new junior doctors was positive and a programme of training was in place for the year. A training programme for core medical trainees was being developed at the time of our inspection and was not set out for the whole year. Junior doctors felt supported out of hours and there was a clear policy and procedure for out of hours work. Handover was seen to be effective
Surgery		There were sufficient doctors available during weekdays, but cover at the weekends and out of hours did not always follow the trust's operational policy. Most junior and trainee doctors had appropriate senior supervision and support when on duty and they felt competent and confident to perform their tasks. There was positive feedback from all junior doctors about their induction programme.

Summary of findings

Critical care

Medical staffing in the high care unit was not in line with the core standards for intensive care units (2013). Junior medical staff were left as the sole doctor on the high care unit out of hours. However, they said that they felt supported in their role, advice and guidance was provided when required and they did not have to undertake tasks they felt ill-prepared or confident to carry out.

The trust took immediate action following our inspection to ensure that there was sufficient medical staffing and to ensure junior doctor support.

Weston General Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care

Detailed findings

Contents

Background to Weston General Hospital

Weston Area Health NHS Trust provides acute hospital services and specialist community children's services to a population of around 212,000 people in North Somerset and around 47,000 people in North Sedgemoor, with over 70% of people living in the four main towns of Weston, Clevedon, Portishead and Nailsea. A further 3.3 million day trippers and 375,000 staying visitors increase this base population each year.

It has three locations that are registered with the Care Quality Commission. These are Weston General Hospital which has 265 beds, The Barn in Clevedon and Drove House which both provide special children's services.

In 2013/14 the annual turnover (total income) for the trust was £96,732,000, the full cost was £101,415,000 which mean the trust had a deficit of £4,683,000.

At the time of our inspection the trust was subject to a transaction process, in which Taunton and Somerset NHS Foundation Trust was the preferred acquirer. This was at the Trust Development Authority's Gateway 2.

Deprivation in North Somerset is lower than average. North Somerset is ranked 201 out of 326 local authority districts across England in the Indices of Multiple Deprivation. However, pockets of deprivation exist in and around the coastal areas.

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

North Somerset performs in line with or better than the England average on a wide range of public health data including children's and young people's health, adult health and lifestyle and disease and poor health. It performs worse than the England average in just one indicator, drug misuse

We inspected this trust as part of our in-depth hospital inspection programme. The trust was selected as it was an example of a moderate risk trust according to our new intelligent monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations.

The trust is not a Foundation trust

The inspection team inspected the following eight core services at Weston General Hospital

- Urgent and emergency services
- Medical Care (including older people's care)
- Surgery
- Critical care

Detailed findings

Our inspection team

Head of Hospital Inspections: Mary Cridge, Care Quality Commission

Inspection Manager: Catherine Campbell, Care Quality Commission

The team included two CQC inspection managers, a CQC inspector and a junior doctor.

How we carried out this inspection

We carried out an unannounced inspection on 17 and 18 August 2015.

We talked with doctors and nurses from the emergency department, on medical and surgical wards and in the high care unit. We observed how people were being cared for and reviewed patients' records of their care and treatment.

We reviewed information which we requested from the trust following our inspection.

Facts and data about Weston General Hospital

Weston Area Health NHS Trust provides acute hospital services and specialist community children's services to a population of around 212,000 people in North Somerset.

In 2013/2014 the trust had 18,347 inpatient admissions, including day cases, 145,344 outpatients attendances (both new and follow up) and 57,790 attendances at accident and emergency department,

At the end of 2013/14 the trust had a financial deficit of £4,683,000.

Bed occupancy was over 90% for the majority of 2013/14 reaching a high of 99.2% in the second quarter of the year. It was above England average (85.9%) all year and above the level, 85%, at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients and the orderly running of the hospital.

The trust had a relatively stable executive team at the time of our inspection, the majority having been in post for at least 2 years. However, the chief executive had had been in post for two weeks at the time of our inspection. Recruitment for a chief executive to see the trust through this transitional period was in place at the time of our inspection. There were five non-executive directors in place at the time, one of whom had been appointed as the chair in May 2015. They had been with the trust for some time. Another of the non-executive directors was new to the trust and had started work at the end of July 2015.

CQC inspection history

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

Safety and welfare of people using this service. Since then we have undertaken a further two inspections at Weston General Hospital and all standards inspected were found to be met.

Inspections have also been undertaken at Drove House and The Barn in September 2011 and October 2011 respectively at which all standards inspected were found to be met.

Detailed findings

A comprehensive inspection of the trust was undertaken in May and June 2015. This covered all of the locations the trust had registered with the CQC.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	N/A	N/A	N/A	N/A	N/A	N/A
Medical care	N/A	N/A	N/A	N/A	N/A	N/A
Surgery	N/A	N/A	N/A	N/A	N/A	N/A
Critical care	N/A	N/A	N/A	N/A	N/A	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Urgent and emergency services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The Emergency Department (ED), otherwise known as the Accident and Emergency Department (A&E) serves as the main emergency department for a local resident population of over 203,000 people as well as the 3.3 million day trippers and 375,000 staying visitors that visited the area each year. The emergency department provided care to approximately 57,790 (10,400 of which are children and young people under the age of 16) patients each year.

As the emergency department was not a designated trauma unit, severely injured trauma patients were usually taken by ambulance to a trauma unit or trauma centre in Bristol or Taunton depending on the location of the incident.

Patients received care and treatment within the emergency department in three main areas; the main waiting area with triage rooms, minors and majors. Self-presenting patients with minor illness or injury were assessed and treated in the minors' area. Direct admissions from GP surgeries were seen in the minors' or 'majors' area. The minors consisted of four cubicles, a waiting area and a dedicated children's cubicle. The majors' area had a total of 12 cubicles, four of which were in the resuscitation room. These areas were accessed by a dedicated ambulance entrance.

The department does not provide a service to children who require emergency admission overnight. These children are automatically diverted to the specialist children's hospital in Bristol or the children's unit at Musgrove Park Hospital in Taunton.

We visited the department over two weekdays and spoke with medical staff ranging from Foundation Year 2 (FY2) doctors to consultants and members of the nursing team.

Summary of findings

Although there were sufficient medical staff deployed to ensure the safety of patients, improvements in the number of medical staff were required to ensure the sustainability of the service in the long term. Several posts within the emergency department were vacant and currently covered by locum staff, both long and short term. Consultant cover was provided from 8am – 11pm. Outside of these hours, consultants were on call from home. Whilst medical staff were described as supportive and approachable, with junior staff able to check any concerns, there were occasions when responses were short due to workload pressures. Induction into the department was described as good. A training program was in place, although release of staff for attendance at training outside of this was difficult.

Urgent and emergency services

Are urgent and emergency services safe?

Although there were sufficient medical staff deployed to ensure the safety of patients, improvements in the number of medical staff were required to ensure the sustainability of the service in the long term. Several posts within the emergency department were vacant and currently covered by locum staff, both long and short term. Consultant cover was provided from 8am – 11pm. Outside of these hours, consultants were on call from home. Whilst medical staff were described as supportive and approachable, with junior staff able to check any concerns, there were occasions when responses were short due to workload pressures. Induction into the department was described as good. A training program was in place, although release of staff for attendance at training outside of this was difficult.

Medical staffing

- Although there were sufficient medical staff deployed to ensure the safety of patients, improvements in the number of medical staff were required to ensure the sustainability of the service in the long term. Several posts within the emergency department were vacant and currently covered by locum staff, both long and short term. Of the six consultant posts, three were covered by a locum on a long term contract and of the 11 registrar posts, one was covered by bank staff, one as a one year fixed term contract and four were vacant. Of the four vacant middle grade posts, two were awaiting new staff to start.
- Consultant cover was provided from 8am to 11pm. One consultant worked within the department from 8am to 5pm and the second consultant 5pm to 11pm. They were then on call from home from 11pm to 8am. Nursing and medical staff described the consultant remaining in the department beyond those hours on occasion when the department was excessively busy, though rarely after midnight. However, they were not allocated to provide clinical care the following day. Consultant staff were described as being very approachable and happy to attend if called for advice or to attend the department outside of those hours.
- Staff were mindful of the reduction in medical staff numbers from 11pm. We observed nursing staff pre-empt the reduction by instigating an escalation status throughout the hospital at 10pm in order to bring other medical colleagues to the department to facilitate admissions and discharges within the department to reduce patient numbers ahead of the end of the consultants shift. Following the call we observed two junior medical doctors and a medical registrar attend the department. No one from the surgical team attended. Staff told us this was often the case as there were fewer of them in the hospital overnight and they were often too busy to attend.
- There were five foundation year 2 doctors and three ST4 doctors on the emergency department medical rota, who worked staggered shifts across the 24 hour period. This meant there were always two junior doctors on duty at any time, with the exception of between midnight and 8am, when there was only one.
- The medical rota also included registrar level or middle grade doctors, with at least one on duty at any one time. However, the numbers meant at times they were required to work up to 9 days in a row. One described this as being “too much. Your thinking ability goes down and you are so tired.” They said, however, having raised this as an issue, they felt this was being addressed to prevent future occurrences.
- Induction into both the trust and the department was described as good, containing information that was both relevant and concise. The induction also consisted a half day ‘e-learning’, but, as no time had been allocated to undertake this, new junior doctors were looking at how to complete it in their own time. This had raised an additional issue as several had computer systems that were not compatible with the program. This had been raised as an issue and staff described senior medical staff looking at how to facilitate completion of the program during their working day. The trust told us that junior doctors were given a day off in lieu if they completed this programme in their own time.
- We reviewed the formal feedback which had been gathered by the trust about the induction programme for foundation year one doctors. These had positive comments and scores for most elements of the programme. Feedback was requested on what was good about the programme and what could be improved. Comments included: “the shadowing was probably the most helpful part”; “everyone was really welcoming and reassuring”; “good balance between

shadowing and lectures" and "good info, well structured". Suggested improvements included: "more time shadowing"; and "The afternoon shadowing time was less helpful as often the FY1s were finished their jobs or were too busy to spend time with us. The mornings tended to be better and of course the full days were most useful."

- One new doctor described their induction experience and initial time in the department as "exceed[ing] expectation". Expectations had been low after receiving feedback from their predecessors, however these issues had not materialised and the doctor reported being "surprised in a good way".
- In order to support junior medical staff an additional matron had been put into the emergency department for a period of 12 weeks. Senior nursing staff had a desire to increase the support available from nurses. However, it was felt that this had been met with some resistance by senior medical colleagues within the trust.
- Consultants were described as 'keen to help, always accessible.' They were said to be often working 'on the shop floor' or within their offices where the office doors were always open. We observed junior doctors discuss cases with consultants throughout our visit.
- Junior doctors we spoke with in the department described discussing every patient with the middle grade doctor on duty as they were only at the very beginning of their rota in the department. They described the response positively, describing the registrar as being available and happy to discuss every case in order to raise their levels of confidence. However, one junior doctor described registrar support as variable due to the large number of middle grade doctors who were locums some of whom were described as being 'better than others'.
- In general, junior medical staff described feeling well supported and practicing within their competency levels. They told us they did not get asked to undertake tasks they were not competent to carry out unsupervised. However, one junior doctor described being asked on only their second shift in the department, to undertake a legal administrative task they had not done before. Identifying this as a gap in their knowledge, they requested help from the consultant on duty as the middle grade doctor in the department was with a sick patient. However, they were told to "just do it". They therefore completed the task with support from a social worker. However, three days later they reported receiving a call to inform them it had not been completed correctly. The doctor described feeling pressurised into undertaking the task, but also described this as an isolated incident with one individual. We raised our concerns regarding this with the trust at the time of the inspection who immediately commenced in investigation of the incident.
- Whist most staff were described as supportive of junior doctors, one member of staff described senior staff being "short" with their answers and advice on occasion when the department was busy or the senior doctor was tired. Another described feeling they were asking too many questions which at times could be met by 'tutting' and 'sighing'. However, they did not feel this to be a person specific issue or a cultural response, rather as a result of a busy department at night that had only two doctors present. We were also provided with several examples of supportive practice. For example, one junior doctor described a consultant remaining in the department beyond their shift in order to supervise the junior doctor undertake a clinical procedure they had not done for some time. Whilst nurses described the department as busy, with medical staff described as 'stretched' they were not able to recall an occasion were they could not get a doctor for help or support when requested.
- Weekly training sessions were in place for junior doctors, one hour per week for foundation level doctors and two hours per week for those following the GP training scheme. In addition a half day training session was held monthly for GP trainees. Cover was provided within the department to enable all trainees to attend. An education program had been developed encompassing a broad range of topics and was described as being open for feedback. One junior doctor described being part time which meant several training sessions fell on their days off. They had raised this with the emergency department rota coordinator and had been told they were looking at ways to address this. The number of junior doctors on the rota also made release for study leave to attend conferences etc. difficult as there was not additional capacity to cover shifts.

Urgent and emergency services

- Whilst 'on the floor' teaching was conducted, junior medical staff described some occasions when the workload within the department prevented them from observing procedures.
- Junior doctors described receiving feedback from incidents via email, pointing out learning which they then described as adopting into their own practice. They described this as being a positive way to learn. Junior doctors also received weekly teaching scenarios via email to work through, with answers provided at the end of the week. Emergency paediatric care teaching sessions were also held weekly. In addition staff described 'micro teach' sessions which were conducted throughout the week.
- We reviewed all incidents reported during the period 5 July 2014 to 25 August 2015. A total of 365 incidents were reported by ED staff during that time of which only one related to medical staffing (non-attendance into the department by orthopaedics doctors following a trauma call).

Are urgent and emergency services effective?
(for example, treatment is effective)

Are urgent and emergency services caring?

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Are urgent and emergency services well-led?

Medical care (including older people's care)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Medical care was delivered by the emergency care division (the division) which was responsible for all unscheduled care. Services included acute medicine, high care, short stay, stroke, gastroenterology, cardiology, care of the elderly, rehabilitation, endocrinology and respiratory medicine. For the purposes of this report, high care is reported under critical care.

The trust admitted 16,973 medical patients in 2013/14. There were six medical wards: Harptree ward (22 beds cardiology, short stay medicine and the high care unit), Berrow ward (28 beds gastroenterology and respiratory medicine), Stroke unit (20 beds stroke medicine), Uphill ward (24 beds rehabilitation) and Kewstoke ward (28 beds care of the elderly) and a 27-bedded short stay medical assessment unit (MAU). There was also a 20-bedded 'escalation ward', Cheddar ward, which was opened at times of increased demand. This ward was not open at the time of our visit.

There was a discharge planning team and a discharge lounge based in the Churchill Unit.

The trust provided a range of cancer services including breast, colorectal, lung, skin, gynaecology, palliative care and urology. There was a chemotherapy unit which provided day case treatment and could accommodate up to nine patients.

There was a medical day care unit (MDCU) which provided transfusion or infusion treatment on a planned or semi-planned basis. There was also a day case endoscopy service.

We visited Harptree, Berrow, Uphill and Kewstoke wards, the stroke unit and also the medical assessment unit. We spoke with 13 junior doctors, four specialist registrars and a consultant. We also spoke with members of nursing staff, including a ward sister and an out of hour's co-ordinator.

Medical care (including older people's care)

Summary of findings

Although the numbers of medical consultants employed by the trust required improvement to ensure the sustainability of the service, shifts and on-call were covered through additional work undertaken and by locum consultants. We saw that action had been taken since our last inspection to ensure that junior doctors received support and training. Junior doctors reported that they felt supported and had not been in a position where they were required to undertake procedures or activities for which they felt ill prepared, trained or supported to carry out.

Feedback on the induction of new junior doctors was positive and a programme of training was in place for the year. A training programme for core medical trainees was being developed at the time of our inspection and was not set out for the whole year.

Junior doctors felt supported out of hours and there was a clear policy and procedure for out of hours work. Handover was seen to be effective.

Are medical care services safe?

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Medical staffing

- There were a number of senior medical posts within the trust which were covered by locums. The establishment number of consultants within medical services was 13 whole time equivalents. In addition there were three whole time equivalent consultants in medical cardiology. However, at the time of our inspection there were only 6.8 whole time equivalent consultants actively in post (excluding medical cardiology). There were four whole time equivalent consultant locums and three vacant positions where no locum had been sourced to provide cover.
- The trust had set up a working group with neighbouring NHS trusts and foundation trusts in order for support to be found in covering the vacant consultant roles in the trust. This was ongoing at the time of the inspection, although no additional consultants had been engaged.
- There was a process in place for ensuring that locums employed within the trust could supervise junior doctors. Curriculum Vitae were checked by a specialty consultant to ensure their suitability and essential criteria had been identified. Details of commitments and expectations were clarified with long term locums

on commencement of their position. An example of this was provided to us. This clearly identified their responsibilities with regards to teaching and supervising junior doctors.

- There was a policy for rota management within the department of medicine. This stated that the rotas would be devised and communicated with no less than eight weeks' notice.
- The consultant rota was arranged on a one in 11 basis, therefore requiring 11 consultants to be on the rota. Only five consultants undertook on call. The rota was covered by consultants undertaking additional shifts and by using agency locums.
- There were named consultants responsible for ensuring that the medical rota for registrars and junior doctors were in place and for ensure this that cover for gaps had been arranged.
- Middle grade doctor posts were fully recruited to, through Deanery appointed trainees, trust appointed roles and long term agency locum cover. There was a full cohort of junior doctors who had started two weeks prior to our inspection.
- It was not clear how the number of doctor posts in the hospital had been determined. We were told that it related to the number of posts commissioned by the local clinical commissioning group and was historic.
- Despite the vacancies in consultant posts junior doctors reported that they felt supported in their role. Some foundation year one doctors said that their support and advice came from the senior house officers, although all said that they felt able to contact their registrar or consultant directly for support. All said that consultants had encouraged them to contact them or call them if they required advice or support with any patient.
- None of the junior doctors we spoke with said that they had been in a position where they had had to undertake a procedure or activity for which they felt ill prepared or equipped.
- Junior medical staff reported that they felt supported in their role. Although most were new to the trust, having only been in post since the beginning of August 2015, they all said that they had received a good induction programme and were provided with the support they needed. Comments regarding the induction programme included "[I was] glad to have so much time on the wards. Other places [hospitals] junior doctors didn't have so much time on the wards; induction was more classroom based".
- We reviewed the formal feedback which had been gathered by the trust about the induction programme for foundation year one doctors. These had positive comments and scores for most elements of the programme. Feedback was requested on what was good about the programme and what could be improved. Comments included: "the shadowing was probably the most helpful part"; "everyone was really welcoming and reassuring"; "good balance between shadowing and lectures" and "good info, well structured". Suggested improvements included: "more time shadowing"; and "The afternoon shadowing time was less helpful as often the FY1s were finished their jobs or were too busy to spend time with us. The mornings tended to be better and of course the full days were most useful."
- Junior doctors said that they had found the first foundation tutorial session (which had occurred the Thursday prior to our inspection) informative. We saw there was a programme in place for each week until the end of January 2015 and some sessions had been identified from January 2016 to the end of July 2016.
- We were told that a geriatric and stroke education meeting which had been developed, the first meeting of which occurred in the week prior to our inspection. There was positive feedback regarding this. The second session occurred on the day of our inspection. This was well attended by medical staff. The junior doctors were actively encouraged to participate, by being prompted to make comments and answer questions. Cases were presented by junior and senior doctors within the meeting. We observed that they were well supported by senior doctors (registrars and clinical fellows) who ensured teaching was at an appropriate level and pertinent to their role. We were provided with a copy of the programme to December 2015. This was a four week cycle of sessions on: a core topic; case discussions; governance and quality improvement; and journal review session. The core topics had been identified to December and included: acute stroke; delirium vs dementia; falls and reduced morbidity; frailty/ rehabilitation; and continence.
- A programme of physicians "grand rounds" was in place starting from September 2015. Consultants had been assigned to lead each session and they included monthly mortality and morbidity reviews.
- A weekly programme of core medical trainee teaching was being developed. Some sessions had been

allocated and identified up to the beginning of October 2015. However, not all weeks had a topic or presenter identified. We were told that medical trainees had been given a blank teaching calendar and asked to "devise and organise their own teaching". We were also provided with a copy of the core medical trainee teaching programme for the previous year from August 2014 to June 2015. This showed teaching sessions had occurred on all but nine weeks, two of which were Christmas and New Year.

- We observed a ward round on the stroke unit, which involved the review of new patients and those who required more regular consultant input. We saw there was active teaching of junior doctors throughout the ward round, with the consultant engaging and teaching the junior doctors through the diagnosis of patients.
- Consultant led ward rounds of a whole ward occurred once or twice a week. Consultants visited the wards most days to review new patients and those who were more seriously ill. Patient records demonstrated that this occurred.
- We were told that weekend plans of care were directed by the consultant, if there was a ward round on a Friday or by a registrar if not. This was evident in the records we reviewed, although all of these patients were medically fit for discharge and were waiting for a package of care to be made available to them in the community. An action being taken was to work with partners to reduce the number of patients who were medically fit for discharge within the hospital, through the opening of a new facility. However, although an urgent priority, this had not occurred at the time of our inspection.
- On Uphill Ward, which was a rehabilitation ward, there was only one junior doctor (a clinical fellow who was not in a training programme at the time of our inspection) providing medical care to the ward between 9am and 5pm. A consultant undertook a weekly ward round and a registrar was available to provide support as necessary. At the time of our inspection a locum consultant was providing cover for the ward and visited each day to see if the junior doctor required support. However, this was not usual practice on the ward. The junior doctor felt capable of undertaking the tasks required on the ward, and felt the autonomy of the role was useful experience. They felt supported by senior doctors, but isolated from the rest of the hospital. It was reported by nursing staff that the junior doctor often worked over their contracted hours in order to ensure that the clerical work involved in the role was completed.
- We reviewed the incident reports relating to medical services between 5 June 2015 and 25 August 2015. Of the 321 incidents relating to medical services, only three related to medical staffing and support. Two were regarding doctors not answering their pager call and the third was regarding a procedure which could not occur because there was not sufficient medical staff available. Few of the incidents reported had been done so by doctors.
- An anonymous telephone hazard reporting system for doctors was being piloted within the hospital. This was to increase the numbers of near misses, hazards and concerns reported at the hospital by doctors. We saw a list of the hazards which had been reported between 28 July and 8 August 2015, 29 had been reported. Only one related to medical staffing and was a concern regarding the number of junior doctors scheduled to be covering Kewstoke ward on the first day of the new team's rota. An immediate review of staffing was undertaken and additional senior cover was engaged to ensure suitable staffing on that shift.
- There was a hospital out of hour's team which was clearly defined. One medical registrar, one medical senior house officer and one medical foundation year one doctor covered the medical wards at night. The medical registrar led the clinical team out of hours.
- We observed handover between day and night staff which had a defined process of handover from junior staff to junior staff, and registrar to registrar etc. Specified jobs were assigned to junior doctors and patients for monitoring out of hours were highlighted. All the junior doctors we spoke with who had undertaken out of hours work said that they felt supported. All said that they felt able to call the registrar or consultant on call if there were an issue and that they had been encouraged to do so.

Are medical care services effective?

Are medical care services caring?

Medical care (including older people's care)

Are medical care services responsive?

Are medical care services well-led?

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Weston Area Health NHS Trust provided a range of surgery services at Weston General Hospital. The hospital had a main theatre unit with four operating theatres, and a self-contained 15-bed day surgery unit with two operating theatres. Surgery provided included general, urology, orthopaedic, breast, colorectal, and upper gastro-intestinal. Surgery was provided as both elective (planned) and in an emergency. The hospital also provided some interventional radiology: a process of using minimally invasive image-guided procedures to diagnose and treat diseases.

The hospital had two main surgery wards located opposite the main theatre unit: Steepholm, a 22-bed ward (for patients having planned or elective operations/ procedures) and Hutton, a 27-bed ward (for patients having emergency operations/procedures). The smaller Waterside ward, with 12 beds, was also used for surgery patients, both NHS and privately funded. Within surgery services, the hospital had a patient pre-operative assessment unit and an eight-bed surgery assessment unit (SAU) for patients coming either through the emergency department or admitted via their GP. The SAU was combined with the Clinical Decisions Unit (CDU) which supported medical patients coming through the emergency department or via their GP.

We made an unannounced visit on the evening of Monday 17 August and during the day on Tuesday 18 August 2015. We visited the two main surgery wards: Steepholm and Hutton, and the surgery assessment unit (SAU). We spoke with staff, including ward sisters, consultants, senior doctors, junior doctors and nurses. We also looked at records and data.

Summary of findings

There were sufficient doctors available during weekdays, but cover at the weekends and out of hours did not always follow the trust's operational policy.

Most junior and trainee doctors had appropriate senior supervision and support when on duty and they felt competent and confident to perform their tasks. There was positive feedback from all junior doctors about their induction programme.

Surgery

Are surgery services safe?

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Surgical staffing

- There were sufficient doctors across the surgery services during weekdays. The establishment of consultants for the surgery division (including general, urology, orthopaedic, breast, colorectal, upper gastro-intestinal and anaesthetics) totalled 30.2 whole time equivalents. At the time of our inspection there were 3 whole time equivalent vacancies. There were also a number of registrar posts which were vacant. The trust confirmed most gaps were backfilled by existing consultants taking extra paid duties or flexing their job plans to meet service demands. A small number were covered by previous employees taking on locum work or by agency staff. The trust had set up a working group with neighbouring NHS trusts and foundation trusts in order for support to be found in covering the vacant consultant roles in the trust. This was ongoing at the time of the inspection.
- The establishment of specialty doctors totalled 8 whole time equivalents with 2 whole time equivalent vacancies. The trust advised us the gaps were being covered by either offering extra shifts at locum rates to existing staff, staff who previously worked at the hospital or agency staff. On occasion consultants were required to act down into the middle grade posts to ensure service continuity.
- All core surgical trainee posts had been withdrawn by the Deanery (due to a national reduction in the number of surgical trainees) and this had impacted on the capacity of the remainder of the surgical team. One registrar was concerned that the middle tier of doctors was being eroded which would remove the bridge between consultants and junior doctors. Opportunities for on the job training were limited with senior doctors expressing frustration because they were often unable to impart their knowledge, while junior doctors were concerned they were missing out on this experiential learning.
- There were 14 junior doctors who had started in the weeks prior to our inspection. There were three vacancies and recruitment was ongoing to fill the posts.
- As a result of concerns raised about the out-of-hours cover following our previous inspection in May and June 2015, the trust were reviewing and revising the additional support required at weekends and out-of-hours to ensure improved senior cover. However, during our evening visit the cover did not meet the trust's out-of-hours operational policy. The policy required there to be a medical registrar who was the clinical lead, and for the surgery wards a surgical specialist registrar (grade not mentioned) and a surgical FY2 (second-year trainee doctor). During our evening visit there was a consultant on call (who was in the hospital until 3am), a senior house officer (SHO) and an FY1 (first-year trainee doctor).
- A surgical registrar told us about their weekend rota for the next six months. Five weekends during this period would be covered by a substantively employed registrar, with the remaining weekends being covered by locums. The shortage of substantive registrars created pressure for the team with staff feeling isolated and unable to pursue training opportunities. The trust confirmed they were addressing the capacity gaps as part of their ongoing staffing review and revision and posts had been filled by locums and clinical fellows.
- There were processes in place to assess the competency of bank or agency doctors to provide supervision of junior doctors. The trust stated that, as most gaps were filled by existing employees, they were subject to the trust's internal governance and appraisal processes. For those who were not current employees, they were subject to the General Medical Council's revalidation procedures and appraisal which covered training competencies.
- There was availability of consultants on call at all times. Consultants were available by telephone or if required or decided to attend, either lived within a 30 minute journey of the hospital or would be resident at the hospital when on-call. All doctors felt well supported

out-of-hours and told us consultants had encouraged them to make contact if they had any concerns and regularly emphasised the importance of doing so. In total we spoke to 15 junior doctors and most felt they were acting within their field of competency and confidence. However, two junior doctors raised concern about the level of cross specialty cover they were expected to provide during their initial out-of-hours shifts. They felt this had not been clearly explained with advice to prepare more fully for the specialties they were not particularly familiar or experienced with.

- Consultants and registrars carried out ward rounds. New patients were seen by a consultant first thing in the morning and later in the afternoon if required. The configuration of wards had not changed since our visit in May 2015, although, plans to revert back to surgery specialty arrangements (general surgery, and trauma and orthopaedic surgery) to reduce the number of ward rounds were in place. We observed ward rounds during our day visit. We spoke to six junior doctors who told us they were informative and they were encouraged to participate and ask questions.
- All junior doctors confirmed they had appropriate senior support while on duty and told us the senior doctors were welcoming and approachable. They were always accompanied by a consultant or registrar on ward rounds and although they completed documentation for weekend plans it was under the direction of the consultant during ward rounds, or the midday multidisciplinary meeting held on Fridays.
- We observed handover sessions between doctors which were held in the doctors' mess. Two of the ten doctors we spoke to felt it was too noisy and chaotic in the mess and one doctor felt the sessions would benefit from more senior input with opportunities to learn.
- There were 203 incidents reported on surgical wards between 5 June and 25 August 2015. Of these, two incidents related to the availability of surgical staff to attend wards: the first, to write a prescription for medication to take home and the second to review a patient on the surgical assessment unit.
- A telephone hazard reporting system for doctors was being piloted within the hospital. This was to increase the numbers of near misses, hazards and concerns reported at the hospital by doctors. We saw a list of the hazards which had been reported between 28 July and 8 August 2015, Of the 29 reported, one related to the surgery wards but did not concern medical staffing.
- All the junior doctors we met were complimentary about their experience of the recent induction programme for foundation year one doctors. Junior doctors had met with the executive team and the general management team, and had shadowed a number of ward rounds with experienced doctors. We reviewed the formal feedback which had been gathered by the trust about the induction programme. These had positive comments and scores for most elements of the programme. Feedback was requested on what was good about the programme and what could be improved. Comments included: "the shadowing was probably the most helpful part"; "everyone was really welcoming and reassuring"; "good balance between shadowing and lectures" and "good info, well structured". Suggested improvements included: "more time shadowing"; and "The afternoon shadowing time was less helpful as often the FY1s were finishing their jobs or were too busy to spend time with us. The mornings tended to be better and of course the full days were most useful."
- There was access to a weekly training programme where training on common and important surgical topics was provided by consultants and registrars. Regular clinical and educational supervision was also available. Attendance at both training and supervision was monitored and documented. Overall junior doctors felt well supported and were looking forward to their placement at the hospital.

Are surgery services effective?

Are surgery services caring?

Are surgery services responsive?

Are surgery services well-led?

Critical care

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The department of critical care at Weston General Hospital provided a service to patients who needed intensive care (described as level three care) or high dependency care (described as level two care). Patients would be admitted following complex surgery or in the event of medical and surgical emergencies. The critical care unit provided support for all inpatient specialities within the acute hospital and to the emergency department. The five-bed unit had three separate areas linked together. These consisted of two areas with two beds in each, and one single side room. The service was led by a senior sister and a consultant intensivist.

The critical care unit admitted around 300 patients each year, the majority of whom were medical patients. In the six months from July to December 2014, the department admitted around 38% of its patients following surgical procedures (12% elective and 26% emergency/urgent patients). All other admissions were for non-surgical patients.

There was a four-bedded high care unit located within a short stay medical ward, Harptree ward.

This unit accommodated patients who required enhanced levels of monitoring and clinical interventions. This included patients who were classified as level 2 critical care patients. These are patients who would normally be cared for on a high dependency unit or intensive care unit and includes patients who require single organ support.

We only inspected the high care unit on Harptree ward as part of this inspection. We spoke with doctors and nursing staff on the unit.

Summary of findings

Medical staffing in the high care unit was not in line with the core standards for intensive care units (2013). Junior medical staff were left as the sole doctor on the high care unit out of hours. However, they said that they felt supported in their role, advice and guidance was provided when required and they did not have to undertake tasks they felt ill-prepared or confident to carry out.

The trust took immediate action following our inspection to ensure that there was sufficient medical staffing and to ensure junior doctor support.

Critical care

Are critical care services safe?

Medical staffing in the high care unit was not in line with the core standards for intensive care units (2013). Junior medical staff were left as the sole doctor on the high care unit out of hours. However, they said that they felt supported in their role, advice and guidance was provided when required and they did not have to undertake tasks they felt ill-prepared or confident to carry out.

The trust took immediate action following our inspection to ensure that there was sufficient medical staffing and to ensure junior doctor support.

Medical staffing

- Medical staffing in the high care unit was not in line with the core standards for intensive care units (2013). The trust had made changes to the unit since our inspection in May 2015 and had plans in place to "disband" the unit and provide the service in an alternate form utilising the intensive care unit. During our inspection in August 2015, there were four patients in the high care unit two of whom were classified as level 2 critical care patients. There was one foundation year one doctor, a senior house officer and a registrar providing out of hours cover to the medical wards in the hospital (including the high care unit). These are patients who would normally be cared for on a high dependency unit or intensive care unit and includes patients who require single organ support. There was one foundation year one doctor, a senior house officer and a registrar providing out of hours cover to the medical wards in the hospital (including the high care unit). We observed that during the evening of 17 August 2015 and early in the morning of 18 August 2015 the foundation year one doctor covering on-call was the only doctor within the high care unit. The core standards for intensive care units (2013) states "an ICU [intensive care unit] resident may be a medical trainee, SAS doctor or Advanced Critical Care Practitioner. It is not appropriate for a foundation year doctor to be left as the sole resident doctor on an ICU."
- We spoke with the junior doctor who had provided out of hours cover to all of the medical wards including the high care unit on the 17 and 18 August 2015 at the beginning and end of their shift. They said they had received the support they required during that shift. They said that the senior house officer and registrar had provided support during the night regarding a patient that they were unsure of how to manage. They felt the advice and support provided by the registrar by telephone was helpful and that they were able to provide the treatment to the patient. They said that if they felt out of their depth they asked for support, which was provided.
- We raised our concerns regarding the medical staffing on the high care unit with the trust during our inspection. The trust took immediate action to rectify the matter, by clarifying within their operational policy that no level 2 critical care patients were to be admitted to the unit and that if an existing patient's condition should change to be classified as level 2, they would be immediately referred to the intensive care unit. A formal process for a consultant to agree admission to the high care unit was implemented. Alongside this an immediate review of the doctor rota was undertaken to ensure that no foundation year doctors were scheduled to cover the unit alone without supervision. In addition the trust was escalating their action to "disband" the unit by 4 September 2015.
- There were 86 incidents reported on the intensive care unit and Harptree Ward, where the high care unit was situated. None of these related to the numbers of medical staff or the support provided to junior doctors.
- We reviewed the formal feedback which had been gathered by the trust about the induction programme for foundation year one doctors. These had positive comments and scores for most elements of the programme. Feedback was requested on what was good about the programme and what could be improved. Comments included: "the shadowing was probably the most helpful part"; "everyone was really welcoming and reassuring"; "good balance between shadowing and lectures" and "good info, well structured". Suggested improvements included: "more time shadowing"; and "The afternoon shadowing time was less helpful as often the FY1s were finished their jobs or were too busy to spend time with us. The mornings tended to be better and of course the full days were most useful."

Are critical care services effective?

Are critical care services caring?

Critical care

Are critical care services responsive?

Are critical care services well-led?

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The trust must ensure that there are suitable numbers of doctors to ensure that a sustainable service is maintained.

Action the hospital SHOULD take to improve

- The trust should continue to work with partners to ensure that patients who are medically fit for discharge are provided with care in an appropriate setting.
- The trust should continue to provide effective support, training and supervision to junior doctors within the trust.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3): Staffing.** **The trust must ensure that there are sufficient numbers of suitably qualified, competent, skilled and experienced doctors deployed within the hospital.**