Weston Area Health NHS Trust

Quality Report

Weston General Hospital
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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Summary of findings

Letter from the Chief Inspector of Hospitals

We conducted this focused inspection to follow up on concerns identified in a Section 29A Warning Notice served in April 2019, following a comprehensive inspection of the service in February 2019. The warning notice set out the following areas of concern, where significant improvement was required by 5 July 2019:

Urgent & Emergency Care

- There were not effective systems to monitor safety and risk. Incidents were not always investigated promptly and there was inadequate evidence to demonstrate that identified risks, incidents, deaths and unexpected outcomes were regularly discussed, and learning shared to improve patient safety.
- There was inadequate oversight of clinical audit and insufficient evidence that audit was used to drive improvements in safety and patient outcomes.
- Staff in the emergency department did not receive adequate support, training and supervision to carry out their roles and responsibilities. Junior doctors expressed concerns about a lack of supervision and engagement from some senior medical staff. There was inadequate oversight of nurse training.

Specialist Community Mental Health services for children and young people

- Staff in the child and adolescent mental health service (CAMHS) were not actively monitoring the risks of young people waiting for assessment and treatment
- Staff in CAMHS were not documenting risk assessments for all young people receiving care within the service
- Staff in CAMHS did not maintain young people's confidentiality through safe record keeping.
- Managers did not effectively assess or monitor quality, safety and risk in CAMHS.

At this follow up inspection we found the trust had achieved some progress in addressing our concerns; however, there was still work to do. We judged that the requirements of the warning notice had not been fully met in Urgent and Emergency Care. We judged that the specific requirements of the warning notice had been met within the Specialist Community Mental Health services for children and young people, although there remained actions for the service to take.

In Urgent and Emergency Care we found:

- Governance systems were still not operating effectively.
- There was limited assurance with regard to the skills of nursing staff in the emergency department. There was no structured training plan or system of staff supervision.
- Whilst junior doctors were mostly positive about the support and supervision they received, there remained some concerns, particularly about support at weekends.

However:

- Many changes had taken place since our last inspection, including senior staff changes. There had been concerted efforts to make improvements and a positive "can do" attitude was evident among senior staff.
- Governance systems and processes had been reviewed and strengthened and a new governance lead for the emergency department had been appointed.
- Quality improvement meetings had been established, including mortality and morbidity reviews, where deaths and unexpected outcomes were reviewed.
- National audits were being used to drive improvement and clinical guidelines were being reviewed to ensure they were up to date and fit for purpose.
- A competency framework for all grades of nursing staff working in ED had been developed and a practice development nurse had been appointed to support the oversight and delivery of training.

Summary of findings

In Specialist Community Mental Health services for children and young people we found:

During this inspection we found:

- The risk of young people on the waiting list was monitored by staff and managers maintained oversight of this. Care records contained clear and comprehensive risk assessments, and risk management plans were present where required. Managers had delivered specific training on care records and risk assessments.
- We were assured sufficient priority and resources had been allocated by the trust to address issues around paper care records. The service had secured funding for an electronic care recording system and were in the process of exploring which application to purchase.
- The trust had recruited a clinical nurse lead to maintain oversight of clinical activity within the team, this included management of caseloads, waiting lists, supervision and training.
- Managers had ensured the service was fully recruited to, promoting optimal capacity of the team. Temporary staff had also been recruited to support with reducing the waiting times for people on the waiting list. The time young people were waiting between assessment and referral had reduced.
- Managers had developed processes and policies to ensure the service was managing risk appropriately and governance structures had been put in place although were not yet embedded fully. Managers were actively reviewing the service to develop ways of improving efficacy and quality of service delivery. Managers maintained oversight of the performance, quality, safety and efficiency of the service.
- Managers were aware of incidents that had occurred and were able to give us examples of how practice had changed to prevent incidents reoccurring. We saw evidence that managers were more engaged in learning from incidents than they were at the previous inspection.
- Managers were monitoring staff stress levels and encouraging staff to provide feedback.

However:

- The use of paper care records continued to cause risk. Reported incidents showed occurrences of a record being misplaced, a referral being missed and a duplicate patient record.
- Whilst risks to patients from ligature points had been identified, no clear actions had been taken to mitigate these risks, and we did not see a clear plan that would address this. This meant that vulnerable children remained at risk.

Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South), on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Urgent and emergency services	**Inadequate** 	• Governance systems were still not operating effectively. We had limited assurance that the main governance forum in the emergency department provided good oversight of quality and risk at departmental, directorate or trust level, in order to support informed decision-making. The risk register was not up to date and was not an effective tool to manage risks or provide assurance that controls were effective. Incident management had improved and serious incidents were investigated and acted upon within appropriate timescales. However, there remained a significant backlog of other incidents and actions arising from incidents. • Although junior doctors were mainly positive about the support and supervision they received from senior medical staff, some still told us that the quality of supervision was variable depending on which consultant was in charge. Concerns were expressed about a lack of support and supervision at weekends. Middle grade doctors were unhappy about a lack of teaching and educational opportunities and a number of staff had left or were considering leaving for these reasons. • There was limited assurance that the nursing workforce had the skills and experience to provide safe care and treatment. A training needs analysis was underway but this still showed numerous training gaps. Training sessions were being provided but these were ad hoc and did not form part of a coordinated and structured training plan. There was still no structured or formal system of nurse supervision, although some progress had been made in identifying teams to be led by senior nurses. • Overall, the service has made good progress in addressing concerns; however, changes were not fully rolled out or embedded and progress was limited by management capacity. This was in the

Summary of findings

context of a service experiencing intense pressure due to increasing demand for services, poor patient flow in the hospital and continuing staff shortages.

However:

- Governance systems, meetings structures and terms of reference had been reviewed and a new governance lead had been appointed.
- The service had done a lot of work to address our concerns with regard to nurse supervision and training. A competency framework had been developed, a training needs assessment was underway, and a practice education nurse had recently been appointed. There had been a concerted effort to ensure all staff were trained in non-invasive ventilation.
- The service had introduced a quality improvement/training forum, where mortality and morbidity reviews took place and audits were presented.
- There was a programme of clinical audit and a review of clinical guidelines was underway. Action plans had been developed following national audits and there was evidence of actions being progressed.
- The service had identified mentors from a neighbouring trust to support senior medical staff to develop leadership and supervisory skills.

Specialist community mental health services for children and young people

Inadequate

- Managers had ensured the service was fully recruited to, promoting optimal capacity of the team. Temporary staff had also been recruited to support with reducing the waiting times for people on the waiting list. The time young people were waiting between assessment and referral had reduced.
- The risk of people on the waiting list was monitored by staff and managers maintained oversight of this. Care records contained clear and comprehensive risk assessments, and risk management plans were present where required. Managers had delivered specific training on care records and risk assessments.

Summary of findings

- We were assured sufficient priority and resources had been allocated by the trust to address issues around paper care records.
- The trust had recruited a clinical nurse lead to govern and maintain oversight of clinical activity within the team.
- Managers had good oversight of incidents that had occurred and were able to give us examples of how practise may be changed to prevent repeated incidents reoccurring.
- Managers had developed process and policies to ensure the service was managing risk appropriately. Governance structures were in place to monitor the key areas of the service to identify risk. Managers were actively reviewing the service to develop ways of improving efficacy and quality of service delivery.
- Managers maintained oversight of the performance, quality, safety and efficiency of the service.

However:

- Although the risk of people on the waiting list was being monitored, staff had concerns about the process by which this was being completed.
- The use of paper care records continued to cause risk.
- Although managers had started to implement governance structures to review the quality of the service, they were not yet fully embedded to enable us to evidence their effectiveness.

Summary of findings

Contents

Summary of this inspection

Background to Weston Area Health NHS Trust

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

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

Our inspection team

The team that inspected the services included two CQC lead inspectors, two additional CQC inspectors and two specialist advisors: a consultant in emergency medicine and a nurse specialist in children's mental health services. The inspection team was overseen by an inspection manager, Marie Cox, and Amanda Williams, Head of Hospital Inspection.

Why we carried out this inspection

We carried out this inspection to follow up on the specific concerns identified in the Section 29A Warning Notice issued to the trust in April 2019. This inspection focussed entirely on the issues identified in the warning notice and so the service was not rated this time. The ratings obtained from the inspection published in April 2019 therefore remain.

How we carried out this inspection

We conducted this inspection, unannounced on 17 and 18 September 2019. We spent one day in the emergency department; and two days visiting the community children's mental health service.

Inadequate

Urgent and emergency services

Well-led

Inadequate

Information about the service

Urgent and emergency care services are provided in the hospital's emergency department (ED) seven days a week, 365 days a year. The department is open from 8am until 10pm. Night time closure has been in place since July 2017 due to safety concerns relating to a shortage of senior medical staff.

From March 2018 to February 2019 there were 49,095 attendances, of which 24.5% arrived by ambulance and 26.5% were admitted to hospital. Approximately 16% of attendances were children. There is no paediatric cover at night or at weekends and children are taken by ambulance to Bristol or Taunton. The emergency department is not a designated trauma unit. Severely injured patients are taken by ambulance to trauma centres in Bristol or Taunton.

There are two treatment areas in the emergency department. Patients with serious injuries or illness, who mostly arrive by ambulance, are seen and treated in the major treatment area, which has eight cubicles and a resuscitation room. The resuscitation area has four bays, one of which is equipped to treat children. The major treatment area is accessed by a dedicated ambulance entrance. Patients with minor injuries are assessed and treated in the minor treatment area, which has 13 cubicles. At times of high demand, patients are accommodated in the corridor surrounding the major treatment area. There are 12 designated trolley spaces and temporary curtains are used to provide privacy.

Inspection and enforcement history

May 2015: We undertook a comprehensive inspection (reviewing all key questions) and the service was rated requires improvement overall, with safe rated as inadequate. Concerns related to patients not being assessed promptly on arrival in the emergency department and inadequate monitoring of their safety. There was a shortage of senior medical staff and junior doctors felt unsupported.

August 2015: We undertook a focussed inspection to look at concerns raised during our previous inspection in relation to medical staffing and supervision of junior medical staff. There was a shortage of senior medical staff (consultants, middle grade doctors and registrars). Senior medical staff were tired and the rota was not felt to be sustainable.

February and March 2017: We undertook a comprehensive inspection and rated the service inadequate overall. Safe, responsive and well led were rated as inadequate, effective was rated requires improvement and caring was rated good. We had continuing concerns about the fragility of the medical staffing infrastructure and the lack of medical leadership. The emergency department was frequently crowded, with patients queuing in the corridor. There was inadequate support from specialty doctors to review patients in the emergency department, particularly at night. We issued a warning notice, which identified serious concerns about poor patient flow, extended waits in the emergency department and the safety of patients queuing in the corridor.

Following this inspection, the trust took the decision to temporarily close the emergency department to admissions at night (from 10pm until 8am). This closure was implemented due to ongoing concerns about a shortage of senior medical staff at night. The department remained closed overnight at the time of the most recent inspection.

December 2017: We undertook a focussed inspection to review the trust's progress against the requirements of the warning notice. We judged there had been significant progress but change was not embedded.

August 2018: We undertook a further focussed inspection and judged that the service had made sufficient progress against the requirements of the warning notice.

February 2019: We undertook a comprehensive inspection and rated the service inadequate overall. Safe and well-led remained inadequate. Caring remained as good and effective remained as requires improvement. Responsive improved from inadequate to requires improvement.

Inadequate

Urgent and emergency services

Safety concerns related to failure to assess and respond promptly to patient risk and monitor their safety, staff shortage and concerns about their skills training and experience. There was not a cohesive or stable leadership team in the emergency department and this was compounded by a culture in which staff did not feel supported.

April 2019: We issued a warning notice under section 29A of the Health and Social Care Act 2008, setting out our most serious concerns:

- There were inadequate governance systems to monitor quality, safety and risk in the emergency department.
- Staff did not receive adequate support, training and supervision to carry out their roles and responsibilities safely.

During this follow up inspection we spoke with approximately 15 staff. This included the associate medical director for the emergency directorate, the clinical lead and governance lead for the emergency department, consultants, middle grade and junior medical staff, the matron, senior sister, interim associate director of nursing, nursing staff and healthcare assistants.

Summary of findings

This was a follow-up inspection focused solely on the serious concerns identified in a warning notice issued in April 2019 under section 29A of the Health and Social Care Act 2008. Concerns related to urgent and emergency care. The inspection took place in order to assess whether the trust had made sufficient progress against the warning notice. Therefore, we did not rate the service and the existing rating of inadequate stands.

In urgent and emergency care, we saw progress had been made in addressing our concerns; however, improvement plans were ongoing, change was not fully embedded and progress was hampered by management capacity, against a backdrop of intense operational pressure; increasing demand for services, poor patient flow in the hospital and continuing staff shortages.

During this inspection we found:

- Governance systems were still not operating effectively. We had limited assurance that the main governance forum in the emergency department provided good oversight of quality and risk at departmental, directorate or trust level, in order to support informed decision-making. The risk register was not up to date and was not an effective tool to manage risks or provide assurance that controls were effective. Incident management had improved and serious incidents were investigated and acted upon within appropriate timescales. However, there remained a significant backlog of other incidents and actions arising from incidents.
- Although junior doctors were mainly positive about the support and supervision they received from senior medical staff, some still told us that the quality of supervision was variable depending on which consultant was in charge. Concerns were expressed about a lack of support and supervision at weekends. Middle grade doctors were unhappy about a lack of teaching and educational opportunities and a number of staff had left or were considering leaving for these reasons.
- There was limited assurance that the nursing workforce had the skills and experience to provide

Urgent and emergency services

safe care and treatment. A training needs analysis was underway but this still showed numerous training gaps. Training sessions were being provided but these were ad hoc and did not form part of a coordinated and structured training plan. There was still no structured or formal system of nurse supervision, although some progress had been made in identifying teams to be led by senior nurses.

- Overall, the service had good progress in addressing concerns; however, changes were not fully rolled out or embedded and progress was limited by management capacity. This was in the context of a service experiencing intense pressure due to increasing demand for services, poor patient flow in the hospital and continuing staff shortages.

However:

- Governance systems, meetings structures and terms of reference had been reviewed and a new governance lead had been appointed.
- The service had done a lot of work to address our concerns with regard to nurse supervision and training. A competency framework had been developed, a training needs assessment was underway, and a practice education nurse had recently been appointed. There had been a concerted effort to ensure all staff were trained in non-invasive ventilation.
- The service had introduced a quality improvement/ training forum, where mortality and morbidity reviews took place and audits were presented.
- There was a programme of clinical audit and a review of clinical guidelines was underway. Action plans had been developed following national audits and there was evidence of actions being progressed.
- The service had identified mentors from a neighbouring trust to support senior medical staff to develop leadership and supervisory skills.

Are urgent and emergency services well-led?

Inadequate

At our last inspection we were concerned there were not effective systems to monitor safety and risk. Governance meetings were poorly attended, and minutes did not provide evidence to demonstrate senior staff had good oversight of quality and safety. Audit was not used to drive service improvement. Incidents were not always investigated promptly and there was inadequate evidence to demonstrate that identified risks, incidents, deaths and unexpected outcomes were regularly discussed and learning shared to improve patient safety.

Staff did not feel supported. There were long-standing concerns expressed by junior medical staff about a lack of engagement and supervision from senior medical staff. There were also concerns expressed about the clinical competence of some senior medical staff. We judged that the service had not acted swiftly or appropriately to manage poor performance. There was inadequate oversight of nurse training and supervision and insufficient assurance that nurses were suitably skilled and supported.

During this inspection we found that, although the trust had made some progress in addressing our concerns, the requirements of the warning notice were not fully met:

- The main governance forum for the emergency department was still not operating effectively, to ensure good oversight of quality and risk and facilitate informed decision-making. There was no action log maintained to ensure actions were progressed at an appropriate pace. We were not assured that information about quality and key risks was regularly discussed or consistently escalated to the directorate's governance forum and, ultimately, the board. There was little discussion recorded about the risks identified on the emergency department risk register. The register was not up to date and provided insufficient evidence that controls were regularly reviewed.

- Incident management had improved and serious incidents were investigated and acted upon within appropriate timescales. However, there remained a significant backlog of other incidents and actions arising from incidents.
- Although there was evidence that the trust had taken action to address behavioural and performance matters, this had not been fully addressed. Junior doctors were mainly positive about the support and supervision they received from senior medical staff; however, some still told us that the quality of supervision was variable depending on which consultant was in charge. Concerns were expressed about a lack of support and supervision at weekends. None of the junior doctors we spoke with would recommend the emergency department as a place to work. Middle grade doctors were unhappy about a lack of teaching and educational opportunities and a number of staff had left or were considering leaving for these reasons.
- There was limited assurance that the nursing workforce had the skills and experience to provide safe care and treatment. A training needs analysis was underway but this still showed numerous training gaps. Training sessions were being provided but these were ad hoc and did not form part of a coordinated and structured training plan. There was still no structured or formal system of nurse supervision, although some progress had been made in identifying teams to be led by senior nurses.
- Overall, the service had made some progress in addressing our concerns; however, changes were not fully rolled out or embedded and progress was limited by management capacity. This was in the context of a service experiencing intense pressure due to increasing demand for services, poor patient flow in the hospital and continuing staff shortages.

However:

- Governance systems, meetings structures and terms of reference had been reviewed and a new governance lead had been appointed.
- The service had done a lot of work to address our concerns with regard to nurse supervision and training. A competency framework had been developed, a training needs assessment was underway, and a practice education nurse had recently been appointed. There had been a concerted effort to ensure all staff were trained in non-invasive ventilation.
- The service had introduced a quality improvement forum, where mortality and morbidity reviews took place and audits were presented.
- There was a programme of clinical audit and a review of clinical guidelines was underway. Action plans had been developed following national audits and there was evidence of actions being progressed.
- The service had identified mentors from a neighbouring trust to support senior medical staff to develop leadership and supervisory skills

Leadership

At our previous inspection we raised concerns that junior doctors felt unsupported by their senior colleagues. They told us some senior medical staff did not engage well with them or provide adequate supervision. Some concerns were also raised about the clinical competence of some senior colleagues and we judged this had not been effectively managed.

At this follow up inspection, the new intake of junior medical staff was more positive about supervision and engagement from senior colleagues, although some concerns remained about a lack of supervision at weekends, when ad-hoc locums were employed. Junior doctors were not confident about the clinical capability of some locum staff. Trainees spoke positively about two consultants, but the quality of supervision was variable, depending on the senior doctor on duty. The clinical lead had previously held weekly meetings with junior medical staff to provide a forum in which they could raise any concerns. He told us that these meetings were no longer scheduled but juniors had been encouraged to speak with him and he was confident they felt supported and able to speak up if they had concerns. Although mainly positive about their training placements, none of the junior doctors we spoke with would recommend the emergency department to their doctor colleagues as a place to work.

The trust's action plan stated it would "Ensure the correct action has been taken to ensure that emergency department consultants understand their professional obligation and monitor compliance." We asked the clinical lead what actions had been taken to address

behavioural and performance matters. They told us the relevant staff had been spoken to. There had been a notes review undertaken for one of the consultants, but the clinical lead was not aware what the outcome of this review was. We were told that some staff had been offered support with communication style and supervision. There was further support planned, with two consultants from a neighbouring trust identified to provide outreach developmental support for staff identified as requiring support.

The action plan developed by the trust in response to our warning notice was acknowledged by senior staff as challenging. There had been a number of senior staff changes and interim managers appointed. The trust had also sourced help from external bodies such the Royal College of Emergency Medicine, the Emergency Care Intensive Support Team (ECIST) and NHS Improvement's "Getting it Right First Time (GIRFT) programme. The clear message from all senior staff was that much improvement work had been done, but there was still work to do. Progress was hampered by their capacity, against a backdrop of intense operational pressure. Poor patient flow in the hospital meant that the emergency department was frequently crowded, and managers' first priority was to ensure patient safety.

Many staff spoke positively about nurse leadership and the leadership and support provided by two locum consultants; one of whom had taken the lead for medical staff training and the other had been appointed as governance lead. The governance lead had, in a short space of time, made significant improvements, in terms of governance structure, and audit. They had undertaken a review of clinical guidelines but was undertaking this single-handedly and this was not expected to be complete until the new year. They acknowledged that capacity was an issue as they had limited management time allocated to perform this role. They told us they felt well supported by the rest of the front door management team but felt there was still more to do to develop the consultant workforce.

Governance

At our previous inspection we were not assured that governance systems and processes were effective. The main governance forum, the emergency department governance meeting, was poorly attended and poorly led. Minutes were brief and they provided limited information or evidence that quality and risk were discussed to ensure upwards assurance to the directorate and trust-wide governance committees and facilitate informed decision-making. There was no tracking system or action log to ensure actions agreed were reviewed at subsequent meetings.

The trust's action plan committed to "ensure well described governance process for ED that includes all of the current governance strands" and to "ensure that front door governance meeting has clear terms of reference and has regular and well attended meetings, clear agenda, and minutes, with clear risk register."

We were told by the interim associate director of nursing that the governance meetings structure had been reviewed. The main governance forum for the emergency department was now the front door quality and governance meeting and terms of reference had been agreed in June 2019. Front door was the term used to describe urgent and emergency services: emergency department, ambulatory care, medical admissions unit and the frailty service. This committee reported to the trust's quality and governance committee through the emergency directorate's governance committee. We reviewed the minutes of the emergency directorate's governance meetings. In May 2019 there was no front door governance report provided and in July 2019 there was no report provided from the front door governance meeting and there was no representative from the emergency department because the front door matron was unable to attend the meeting due to operational pressure.

A new governance lead had been appointed in May 2019 and they chaired the front door governance committee. We reviewed the minutes from meetings in April, May, June, July and August 2019. Attendance had improved, although it was not consistent. There was no tracking system or action log to ensure that actions agreed were progressed and reviewed at subsequent meetings. For example, at the meeting held in June 2019, under the agenda item, Brought forward from previous meeting, there were seven previously agreed actions recorded, of which only two had been actioned. The remaining actions were not followed up at subsequent meetings. At the following meeting in July 2019, it was recorded that

the minutes of the June meeting were not discussed. Although there were some actions recorded at the July meeting, these were not reviewed at the subsequent meeting in August.

Management of risk, issues and performance

At our last inspection we were not assured that incidents in the emergency department were managed well in order to ensure swift and appropriate remedial actions were taken and learning shared. Incidents were not regularly discussed at governance meetings and there was a large backlog of incident investigations. The trust's action plan committed to "Ensure departmental governance meetings discuss learning from all incidents and complaints and formulate clear actions where appropriate".

We reviewed the emergency department incidents and complaints report (July 2019), which provided an overview and broad analysis of incidents and complaints. It was reported that in September 2019 (the time of reporting), there were 219 outstanding incidents in the emergency department. There were also 23 outstanding actions arising from incidents, one of which was due for completion in October 2018. The front door matron acknowledged the large backlog. She told us senior nurses were assisting in incident management but running a busy emergency department took priority. Incidents were discussed at front door governance meetings, although this item was deferred at the meeting held in August because the front door matron had not met with the governance lead to discuss incidents due to operational pressure. However, serious incidents had been investigated within the required timeframe and there was evidence that actions had been completed. We saw learning was shared at quality improvement meetings and staff handover meetings.

At our last inspection we reported that the risk register was not used to maintain oversight and manage risks effectively. It was not regularly reviewed at the emergency department's main risk forum, the emergency department governance meeting. The trust's action plan did not specifically address this concern, although it stated: "ensure front door governance meeting (this had replaced the ED governance meeting) has clear terms of reference and has regular and well attended meetings, clear agenda and minutes, with clear risk register and action log". We spoke with the governance lead, who told us the risk register had been reviewed by the front door governance committee and new risks had recently been added. These included out of date guidelines, staffing and flooring in the emergency department. We were told that mitigating actions were discussed at governance meetings.

We reviewed the emergency department risk register dated September 2019. There were 32 risks, although some appeared to be duplicates or were very similar. All risks had mitigating actions (controls) recorded but few of the entries were dated so it was not clear that the controls had been recently reviewed and they provided limited assurance.

Eleven risks were overdue for review. One risk, which had been graded as a high risk, had not been reviewed since July 2017. This related to the lack of medical staff trained in paediatric resuscitation. We therefore had no assurance that the controls listed were up-to-date or effective. One of the controls related to advanced paediatric life support training for band six and seven nurses, which we confirmed from training data provided by the trust, had not been achieved. This risk was one of five risks which related to the care and treatment of children, of which three were overdue for review. We were therefore not assured that the service had taken adequate steps to ensure the safe care of children in the emergency department.

The emergency department's clinical lead told us the highest risk currently held by the emergency department was the lack of an agreement with specialities regarding the handover of patients when the emergency department closed at night. This was recorded as a very high risk on the risk register, with a review date of December 2019. The controls recorded were "Standard operating procedure (SOP) in place, ED have admitting rights." We were provided with a draft ED Closure SOP (undated), which had yet to be shared with and agreed by specialties. We were concerned that this significant risk, which had been in place since the night time closure of ED two years ago, did not appear to have adequate controls in place and did not appear from governance minutes, to be a priority.

There was limited discussion about risk or risk controls discussed at governance meetings. We reviewed the minutes of the ED/front door governance meetings from April 2019 to date. In April it was recorded there were 14

risks on the register and it needed to be updated. The biggest risk was staffing, and it was recorded that the department was advertising for staff. In May 2019, it was recorded that training was to be provided in the management of the risk register. It was noted there were 12 risks on the risk register, including staffing and use of the corridor. There was also an action to review risks "as there may be duplicates." In June 2019 it was recorded that "[the governance lead] will check." In July it was recorded that the front door matron and senior sister were reviewing risks and closing as appropriate, including duplicate ones". One risk had been added to the risk register (equipment not working) and there was an update on one other risk, although it was not clear which risk this was. In August 2019, it was again noted that the equipment failure issue had been added to the risk register, as well as low staffing numbers. It was also discussed that overnight ambulance transfers should be added to the risk register and an action was recorded to discuss this with the ambulance service.

There was limited assurance that risks were appropriately escalated to directorate and trust level committees. We reviewed minutes of the emergency directorate governance meetings. The risk register was not discussed or reviewed here; however, the trust provided us with a report (dated 10 June 2019) to the risk management committee, to present updates to the risk register in May 2019. This detailed new risks or changes in the status of risks but provided no assurance with regard to controls and did not address out of date risks.

At our last inspection we reported that the service did not hold regular mortality and morbidity (M&M) meetings to review deaths and other unexpected outcomes. This was on the emergency directorate risk register. The trust's action plan stated "Ensure M&M meetings are occurring within the emergency department and evidence of learning for the wider team is clear. We were told that these meetings, initially known as quality improvement meetings, now took place monthly and were chaired by the governance lead. The first meeting had taken place in May 2019 and subsequent meetings had taken place each month, with the exception of June 2019, when operational pressure prevented attendance. The timing and content of the meetings had been adapted to maximise attendance and learning opportunities. Meetings took place to coincide with scheduled teaching times for junior doctors and had been renamed training meetings. We heard about learning related to the management of end of life and organ donation and teaching had been scheduled to address shortcomings identified through the M&M process. Nursing staff were invited to attend these meetings, although few were able to attend. Learning points were captured in the nurses' handover meetings. There was an action log developed following each meeting.

At our last inspection we were concerned there was inadequate oversight of clinical audit and insufficient evidence that audit was used to drive improvement. There was no evidence that clinical audits, guidelines and protocols were regularly reviewed and discussed at governance meetings. We found some clinical guidelines that were out of date. No action plans had been developed in response to Royal College of Emergency Medicine (RCEM) national audits in 2016/17 or 2017/18.

The trust's action plan detailed three actions in response to these concerns: "Ensure clear audit plan for the department addressing local and national priorities", "Complete departmental review of compliance against all relevant National Institute for Health and Care Excellence (NICE) guidelines", "Ensure action plans for 2017 and 2018 RCEM audits are produced and completed."

We saw that findings from 2017/18 RCEM audits had been presented to quality improvement meetings and action plans signed off at governance meetings. Each of the three current RCEM audits (2019/20) had each been allocated to a supervising consultant and data collection was underway. There was also a programme of departmental audit and a number of quality improvement programmes, arising from incidents and complaints, were being developed, where junior doctors were to be involved. A review of clinical guidelines was underway, and modifications were discussed and reviewed at governance meetings. We were told that the governance lead was undertaking the review of clinical guidelines and had made good progress but because of limited managerial time, they anticipated this would not be complete until the new year.

At our last inspection we reported that staff did not receive adequate support, training and supervision. Nursing staff did not receive regular one to one or group supervision. A newly qualified nurse told us they were not adequately supported, and they were sometimes asked to perform procedures which they had not received

training to perform. The emergency department had not undertaken a training needs analysis or developed a training plan to identify and deliver ED-specific competencies for nurses and healthcare support workers. There was no policy or process which outlined what was expected of staff, how competencies were to be assessed and signed off and how the service was going to monitor this. This meant the service had little oversight or assurance that staff were appropriately skilled and supported in their roles. A staffing review undertaken by the front door matron in March 2019, had identified that exit interviews conducted with staff who had recently left the organisation, had identified that staff felt they did not receive adequate training or support.

The trust's action plan detailed three actions: "review induction information for newly qualified nurses to ensure there is clear explanation of sources of professional support when at work and define minimum standards for provision of mentorship meetings, "carry out training needs assessment and develop training plan for ED staff", ensure clear competency framework for ED staff for implementation and monitoring."

At our follow up inspection, we saw a significant amount of work had taken place to address our concerns. The senior sister in the emergency department had developed a competency framework, setting out the competencies required of all grades of nurses and healthcare support workers. This piece of work had only recently been completed and was awaiting ratification by the governance committee before it was formally launched. There was a training needs assessment underway, developed by consulting individually with staff. This ensured there was improved oversight of the training status of the nursing workforce but this was work in progress and still showed a significant number of training gaps. For example, only one out of 10 band six nurses had completed training in principles of children's emergency care, one had completed spotting the sick child, two had completed paediatric intermediate life support training and three had completed advanced paediatric life support training, and five had completed level three child protection training.

The induction process had been reviewed and supernumerary time increased, to support new nurses. A practice development nurse had recently been appointed. They would take on delegated responsibility for oversight and provision of nurse training. There was no training plan developed as yet but there had been a concerted effort to get appropriate staff trained in triage and to support staff working in the resuscitation area, including training in non-invasive ventilation. We had raised concerns previously that the service had no assurance that staff were trained and confident in this procedure. There had been good progress, with seven out of 10 band six nurses now trained and 14 out of 22 band five nurses trained.

The trust's action plan did not specifically address nurse supervision. The senior sister told us this continued to be challenging to facilitate; however, they had developed a draft team structure, which would allow senior nurses to take greater formal responsibility for the provision of supervision and would ensure nurses had a "go to person" for support. The presence of the practice development nurse in the department had also enhanced supervision.

We spoke with three middle grade doctors. They were unhappy about lack of opportunities for teaching, training, educational opportunities, leadership and support. One was about to leave for these reasons. The clinical lead acknowledged that staff shortage at this level had hampered training opportunities and had recently supported a middle grade doctor to undertake a rotation to gain experience in paediatrics. The trust was also looking at financial incentives and job planning to attract further middle grade doctors.

Specialist community mental health services for children and young people

Inadequate

Safe	Inadequate
Well-led	Inadequate

Information about the service

Weston Area Health NHS Trust provides child and adolescent mental health and learning disability services (CAMHS) from two sites: Drove House in Weston-Super-Mare and the Barn in Clevedon; services are delivered by one multidisciplinary team across the two sites. Community paediatric services were also based at these sites and delivered services from these locations.

The CAMHS teams provide services for children and adolescents with severe and complex mental health issues. The multidisciplinary team provided services from the two main bases but also from clinics, schools, early years settings and in families' homes. The team offered a wide range of therapies/services.

The CAMHS team used set referral criteria to ensure access to assessment and treatment for children and young people who needed it most.

During this inspection we:

- spoke with the Associate General Manager for Emergency Services Directorate, Clinical Service Manager, Business Manager,
- spoke with the Consultant psychiatrist and Clinical Nurse Lead,
- spoke with 18 staff members across two focus groups,
- reviewed eight records for people receiving a service, eight records for people on the waiting list, incidents reports, minutes for business meetings,
- observed a business meeting
- reviewed documentation and data, and the trust's action plan in response to the warning notice.

Summary of findings

At the previous inspection in February 2019, we rated this service as inadequate and served a warning notice which required the trust to make significant improvements. This inspection focussed entirely on the issues identified in the warning notice and so the service was not rated this time. The ratings obtained from the inspection published in April 2019 remain. The warning notice required the trust to make improvements to monitoring children and young people appropriately whilst waiting for assessment and treatment and recording this clearly. It also required that the service improved how it maintained the confidentiality of records. Furthermore the warning notice required that the service improved the way it assessed and monitored the safety and quality of the service being delivered.

At this inspection we found that the trust had made the majority of the required improvements.

During this inspection we found:

- The risk of young people on the waiting list was monitored by staff and managers maintained oversight of this. Care records contained clear and comprehensive risk assessments, and risk management plans were present where required. Managers had delivered specific training on care records and risk assessments.
- We were assured sufficient priority and resources had been allocated by the trust to address issues around paper care records. The service had secured funding for an electronic care recording system and were in the process of exploring which application to purchase.
- The trust had recruited a clinical nurse lead to maintain oversight of clinical activity within the team, this included management of caseloads, waiting lists, supervision and training.
- Managers had ensured the service was fully recruited to, promoting optimal capacity of the team.

Specialist community mental health services for children and young people

Inadequate

Temporary staff had also been recruited to support with reducing the waiting times for people on the waiting list. The time young people were waiting between assessment and referral had reduced.

- Managers had developed process and policies to ensure the service was managing risk appropriately and governance structures had been put in place although were not yet embedded fully. Managers were actively reviewing the service to develop ways of improving efficacy and quality of service delivery. Managers maintained oversight of the performance, quality, safety and efficiency of the service.
- Managers were aware of incidents that had occurred and were able to give us examples of how practice had changed to prevent incidents reoccurring. We saw evidence that managers were more engaged in learning from incidents than they were at the previous inspection.
- Managers were monitoring staff stress levels and encouraging staff to provide feedback.

However:

- The use of paper care records continued to cause risk. Reported incidents showed occurrences of a record being misplaced, a referral being missed and a duplicate patient record.
- Whilst risks to patients from ligature points had been identified, no clear actions had been taken to mitigate these risks, and we did not see a clear plan that would address this.

Are specialist community mental health services for children and young people safe?

Inadequate

At our last inspection we were concerned staff were not actively monitoring the risks of young people waiting for assessment and treatment, were not documenting risk assessment for young people receiving care and did not maintain young peoples' confidentiality through safe record keeping. Significant improvements were required to ensure the systems and processes monitored risk and maintained confidentiality of people on the waiting list and people receiving care within the service.

Safe and clean environment

There were potential ligature anchor points in the service. Staff knew about these points but had not mitigated the risks to keep patients safe.

A ligature risk assessment had been completed for Drove Road and The Barn in July 2019, which identified ligature points. A ligature point is any feature in an environment which could be used to support a strangulation device. However, whilst remedial actions could be described as being managed by staff supervision, we saw no evidence that the issue had been comprehensively addressed.

We did not see that a clear plan of action that described who was responsible for managing the risk of ligature points, or that any mitigations were planned for. The risk to vulnerable patients therefore remained and we were not assured this was being effectively managed.

Assessment of patient risk

Staff completed risk assessments for each patient and reviewed this regularly.

We reviewed eight records for people who had been accepted by the service and were in receipt of treatment. Seven out of eight records had clear and comprehensive risk assessments. Risk management plans were in place where required and were appropriate to the risk and presentation of the person. Although staff were clearly risk aware, there was some variation in how this information

was documented. Five records had completed the risk assessment which encompassed all aspects of the person's life including family, background, presenting risk, lifestyle, physical health etc.

A Standard Operating Procedure (SOP) had been ratified at a trust governance meeting, to provide 'Guidance for staff in completing standardised risk assessments for all Children and Young People seen within the Child and Adolescent Mental Health Service'. Managers had delivered training to staff using this guidance at a development day in August 2019.

Monthly case note audits were being completed by staff to ensure all clinicians were completing risk assessments of high quality and that these were available in the persons records. Ten records were sampled each month and results from these audits were being used to target areas for improvement.

Management of patient risk

Staff knew about any risks to each patient and acted on this to prioritise patients.

At the previous inspection we found there was poor management of risk. During this inspection we found staff assessed and managed the risk of young people well. We reviewed eight records for people on the waiting list. All of these records showed that people had been contacted by staff to complete a risk screen and six of these people had a full risk screen in their records. Two records showed that staff had attempted to complete a risk screen on two or more occasions, within the week prior to the inspection. Although risk screening had been embedded in to the triage and monitoring of waiting lists, risk screening was of varying quality. Four of the risk screening records were well documented, one risk screen had not been dated and one had identified a risk with no detail to show the risk had been explored further.

The waiting-list risk screening template was comprehensive and captured information on various aspects of the persons wellbeing (sleep, mood, concentration), other professional involvement, medication, current presentation, risk formulation and a plan indicating if the assessment required is routine or urgent.

There was evidence of positive impact of people receiving a 'risk screen' whilst on the waiting list. We saw some people had received urgent assessments, some remained on the waiting list, and some no longer required a service. All new referrals from April 2019 onwards had been risk screened at the point of referral and staff were working on older referrals, on a rotational basis. At the time of this inspection, only people referred to the service in February and March 2019 had not been risk screened.

The operations manager completed a weekly report for numbers of people on the waiting list and this information fed into a monthly report produced by the associate general manager. In addition to this, a weekly professional team leads' meeting reviewed any individuals that had been waiting over 30 weeks and an action plan was written. All this information was then given to the trusts' referral to treatment' board to review in a monthly meeting with commissioners and trust managers.

Managers in the service identified that they had not seen as many people as they could have and attributed this to care coordinators holding on to cases for longer than necessarily required. Although not in place at the time of our inspection, the team planned to start bi-weekly multidisciplinary team meetings to discuss discharges and complex cases to help them see more young people.

Staff access to essential information

Staff had access to clinical information and systems had been improved to manage the risks associated with paper records in the community setting. Records were stored securely.

At the previous inspection we found there was poor access to essential information. During this inspection we found incident reports showed that paper records were an ongoing risk. However, staff had improved their practice around the management of patient records. Incidents relating paper care records had reduced and we saw evidence that these incidents had been investigated thoroughly.

Managers had produced and delivered service specific training for staff on clinical records and, security and transport of clinical records. This training covered results from the most recent audit, trust and professional standards, legal requirements, referral to treatment, Did Not Attend policy, and safe practice around transport and security of records.

Specialist community mental health services for children and young people

Inadequate

Managers had included guidance on the safe transportation of records in the Trust confidentiality policy, which had been ratified at a directorate governance meeting. A local CAMHS Standard Operating Procedure (SOP) had been developed and for safe transportation of records between Drove Road and The Barn. We saw evidence that this was being implemented by staff.

Are specialist community mental health services for children and young people well-led?

Inadequate

At our last inspection we were concerned the delivery of high-quality service provision was not assured by the managership, governance and culture. Significant improvements were required to ensure the systems and processes for the CAMHS service were effectively governed.

During this inspection we found:

- The service had responded to most of the warning notice requirements. Governance structures were in place to monitor the key areas of the service to identify risk. Local and senior management held regular meetings which had evidenced monitoring of risk. Managers had developed process and policies to ensure the service was managing risk appropriately.
- Managers were actively reviewing the service to develop ways of improving efficacy and quality of service delivery. Managers maintained oversight of the performance, quality, safety and efficiency of the service. Managers were monitoring staff stress levels and encouraging staff to provide feedback.

However:

- Actions on ligature assessments had not been attributed to a responsible person with a timescale for completion.
- Although managers had started to implement governance structures to review the quality of the service, they were not yet embedded to enable us to evidence their effectiveness.

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood the issues, priorities and challenges the service faced and managed them. They were visible in the service and supported staff to develop their skills and take on more senior roles.

At the previous inspection we found there was poor assessment and monitoring of quality, safety and risk in CAMHS. During this inspection we found management had been reviewed and a clinical service manager had been recruited and started in July 2019.

An associate general manager had been in post since March 2019 and had worked closely with the operational and clinical leads to develop a clear line management reporting structure for all staff.

A clinical service manager (CSM) had been appointed since the last inspection and was demonstrating through action that they had the skills and abilities to effectively lead the service.

Governance

Leaders ensured there were structures, processes and systems of accountability for the performance of the service.

Business meetings for staff of Drove Road and The Barn were being well attended. These meetings covered various areas of the daily running of the service such as clinical governance, staffing, training and processes. Managers were sharing information with staff from other management meetings. The managers had ensured the trust's 'WAHT newsletter' was circulated to all staff, to share updates within the trust and good news stories amongst other useful information.

All new SOPs had been ratified at the directorate governance meetings.

Management of risk, issues and performance

Leaders managed performance using systems to identify, understand, monitor, and reduce or eliminate risks. They ensured risks were dealt with at the appropriate level.

Managers had produced clear processes to manage the waiting lists. A short-term waiting list allocation process chart had been devised for staff to understand how they would be allocated one person from the waiting list per

week to make contact with and report back to clinical services manager. Staff had also been provided with an easy flow chart to follow when contacting the person, and the relevant processes to follow for high, medium, low risk and when contact was unsuccessful. All this information had been delivered to staff in a face-to-face session delivered by the clinical services manager.

Due to the new management of the waiting list, the longest wait for a person on the waiting list had reduced from 44 weeks at the last inspection to 38 weeks at this inspection. Managers were continuing to work towards a specification from commissioners.

At the previous inspection we saw that young people who were aged 17 were sometimes re-referred straight on to adult services as they would not be offered treatment before their 18th birthday due to the long waiting lists. At this inspection we saw that the trust had addressed this issue and written a clear 'Transition Policy – Paediatric to Adult Services' which had been ratified in July 2019. Staff were working closely with the CAMHS to Adult transitions team to support young people transitioning to adult services.

At the previous inspection ligature risk assessments had not been completed. At this inspection we saw that the health and safety lead for the trust had trained the CAMHS business manager to carry out ligature assessments. This meant that CAMHS services could complete and update ligature assessments as and when necessary. Whilst the assessment was completed there still remained outstanding items to address. Either these had not been prioritised to identify high risk areas, such as non-communal areas or no evidence of when or who this was due to be actioned by.

The associate general manager had a clear action plan addressing each of the points raised in the warning notice. This was comprehensive and showed evidence of it being regularly updated as evidence was collated, and actions were completed. This also included input from the local management staff.

The associate general manager for emergency services had devised a spreadsheet to collate the all the action plans for CAMHS improvement. This document specified the concern, what action/s would be required, whom the concern was identified by, the lead maintaining oversight, timescale, evidence required, status (blue, amber, green) and any evidence collated. There was evidence that this was a working document and all relevant information has been added in a timely manner. We saw that senior managers maintained oversight of this information through business and governance meetings, and presented to the quality and safety committee at regular intervals.

There were two pieces of work the CSM was leading on; the monitoring of risk of people on the waiting list and reviewing the work model the team was using to manage their caseloads. The service was using the principle of 'Choice; and Partnership' model (CAPA) to engage young people whilst managing supply and demand. The CSM was in the process of reviewing the efficacy of this model, with the limited quantifiable data that was available from paper records. The model was not seen as maximising the resources within the team and a new model of 'Demand and Capacity' was being explored, to increase throughput and decrease caseloads for staff.

Managers had ensured that the service had a full complement of staff which maximised the capacity of the team, whilst reducing individual staff caseloads.

At the previous inspection the trust had secured capital for IT investment. In July 2019 a business case for capital investment for electronic records was approved. Managers within the service had been developing a delivery plan for the implementation of a digital system for patients records. This had been done with consideration of systems used by other trusts that Weston works closely with, such as Avon and Wiltshire and University Hospitals Bristol.

Managers had identified that staff were feeling stressed and work was in progress to address this. Managers had analysed results from a stress audit in July 2019 and had scheduled to meet with staff at the end of October to discuss the results and explore stress management tools.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Urgent and Emergency Services

- Continue to develop governance systems and processes and review their effectiveness.
- Ensure the emergency department risk register is regularly reviewed and maintained to ensure that it is an effective tool to manage risks and provide assurance that controls are effective.
- Continue to develop systems to ensure good oversight of nursing staff competencies and supervision.
- Ensure nursing staff are adequately supported with ongoing relevant training and supervision.
- Continue to monitor and support senior medical staff in the emergency department to ensure they are equipped to provide the appropriate level of supervision to trainee doctors.

Specialist community services for children and young people

- Take action to address the continuing risks of identified ligature points, particularly non-communal areas.

Action the provider SHOULD take to improve

Urgent and Emergency Services

- Take steps to improve training opportunities for middle grade doctors in the emergency department.
- Review managerial capacity to take forward the significant improvement agenda.

Specialist community services for children and young people

- Develop the focus on the quality and safekeeping of care records
- Continue to further develop systems that review data to monitor the efficacy of the service.
- Complete the environmental risk assessments by identifying when and who changes are due to be actioned by.
- Take actions to further embed the developments since the previous inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The trust had not mitigated the identified risks of ligature points and did not have a clear plan to make this happen.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The trust did not operate efficient systems to monitor quality, safety and risk. A Section 29a warning notice has been issued in respect of this breach of regulation

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The trust did not ensure there were always sufficient numbers of suitably qualified, competent and skilled staff. Staff did not receive adequate support, training or supervision to carry out their roles and responsibilities safely. A Section 29a warning notice has been issued in respect of this breach of regulation.