East Suffolk and North Essex NHS Foundation Trust

Colchester General Hospital

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Colchester General Hospital

Requires Improvement 

Colchester General Hospital is a part of East Suffolk and North Essex NHS Foundation Trust. The trust has two main acute locations which are Colchester General Hospital and Ipswich Hospital.

The trust provides a full range of consultant-led medical care on both acute sites including general and acute medicine, stroke, gastroenterology, cardiology, respiratory, diabetes, endocrine and metabolic medicine, neurology, nephrology. Older People's services include frailty, movement disorder, metabolic bone disease, fragility fractures, falls, dementia, delirium, onco-geriatrics, and interface geriatrics.

Adult and Older Peoples services sit across two individual divisions, North East Essex Community Services (NEECS) and Medicine Colchester. Layer Marney Ward and Nayland Ward are in Medicine Colchester and D'Arcy, Peldon, Birch & Tiptree Ward are in the Division of NEECS.

We carried out this unannounced focused inspection at Colchester General Hospital because we received information of concern about the safety and quality of medical care and older people's services. We inspected 6 of the medical care and older people's wards at Colchester General Hospital. We did not inspect all the core services provided by the trust as this was a risk-based inspection. We continue to monitor all services as part of our ongoing engagement and will re-inspect them as appropriate.

Acute care services for older people at Colchester General Hospital are delivered across four main inpatient wards, with a total 126 beds:

- D'Arcy ward - 30 beds
- Peldon ward - 30 beds
- Birch ward - 36 beds
- Tiptree ward - 28 beds

The stroke unit at Colchester has 33 beds including 6 Hyper Acute Stroke Unit (HASU) beds. The Colchester stroke unit provides care for 710 patients with confirmed strokes each year. Colchester and Ipswich and provide thrombolysis and a 24/7 hyper-acute service on both acute sites.

Colchester has 7 whole time equivalent Consultant Cardiologists and 28 cardiology beds.

Respiratory Medicine services have a large inpatient workload and designated respiratory inpatient beds on both sites: 33 beds at Colchester. At our last inspection in 2019 we rated the service overall as good. We rated all domains, safe, effective, caring, responsive and well-led as good. We inspected medical care and older people's services at Colchester General Hospital. At this inspection we found the core service ratings for medical care and older people's services had deteriorated since our previous inspection in 2019. At this inspection, we rated safe, effective, responsive, and well-led as requires improvement and caring stayed the same rated as good.

Our findings

As part of the inspection, we spoke with staff across all disciplines, including 14 qualified nurses, 2 doctors, 2 consultants, 4 health care assistants, 1 occupational therapist, 1 security staff, external agency support staff and members of senior leadership staff both clinical and operational. We looked at 10 patient records and spoke with 6 patients and 7 family members.

How we carried out the inspection

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

Medical care (including older people's care)

Requires Improvement

Our rating of this service went down. We rated it as requires improvement because:

- Staff were not always up to date with their mandatory training in key skills including safeguarding training.
- The service did not have enough staff to care for patients and keep them safe.
- Staff did not always provide safe care and treatment. Staff did not always respond to the needs of patients.
- Staff did not always complete *risk assessments* for *Venous Thromboembolism* (*VTE*) for all patients.
- Staff did not always communicate discharge information well for patients leaving the wards to return to the community.
- Leaders did not always operate effective governance processes.
- Staff did not always comply with infection prevention control principles.
- Staff did not always comply with legislation to protect patient privacy and confidential information in relation to patient records.
- Staff did not always feel respected, supported, and valued.
- Staff did not always make sure patients and those close to them understood their care and treatment.
- Managers could not always support staff to develop through yearly, constructive appraisals of their work.

However:

- Staff assessed risks to patients, acted on them and kept safe care records.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to useful information. Key services were available 7 days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.
- The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Is the service safe?

Requires Improvement

Medical care (including older people's care)

Our rating of safe went down. We rated it as requires improvement.

Mandatory Training

Staff were not always up to date with mandatory training in key skills and leaders worked with staff to ensure everyone completed it.

Staff were not always up-to-date with their mandatory training. Nursing and associated staff received mandatory training in a comprehensive range of subjects. For example, adult basic life support 87% compliance, sepsis 80%. Training compliance rates were below target across most mandatory training subjects. We looked at the trust's action plan in October to improve training compliance. We saw that at October 2022 there had been an increase across the board to 83% compliance. However, this remained below target of 90%. Managers told us they continued to book staff training to support attendance and continue to improve compliance.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers used a training schedule with upcoming dates for training to be completed. Managers, with support from human resources, highlighted mandatory training as a top area of focus as part of the Accountability Framework. This meant there was focus at a leadership level outlining actions and forecasts for improvement.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Training compliance figures demonstrated most staff were up to date with their training. We saw in October 2022 compliance with child protection level 2 training was 85% and safeguarding adults level 3 were below target at 76%. A new level 2 training programme in Recognising and Safeguarding Adults at Risk was at 100%. Staff received training on mental health awareness and dementia awareness. Staff were supported by specialist safeguarding leads to provide guidance and support when needed.

Staff gave examples of identifying safeguarding concerns. We observed safeguarding discussions at board round which assured us that protecting patients was customary practice.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. We saw many examples of when staff had identified patients at risk and work with other agencies, for example, local authorities to help protect people.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff worked closely with the safeguarding lead who was based in the department. Staff provided us with examples of referring to safeguarding leads. We saw examples of when staff spoke of safeguarding issues with the safeguarding lead. We observed the medical team discussing safeguarding concerns with patients and their families.

All staff had access to a safeguarding adult policy. This was in date and contained all the necessary information to help them with safeguarding concerns. Leadership staff attended a range of safeguarding meetings which met regularly and provided quality updates to the Patient Safety Committee.

Medical care (including older people's care)

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves, and others from infection. The equipment and the premises were not always visibly clean.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). We saw one clinical member of staff in a COVID-19 bay remove items from patients without wearing gloves. We saw a doctor who was not bare below the elbow. This meant they were placing others at risk of infection. Leaders used a ward scorecard to monitor infection prevention control. The metrics included audits of PPE compliance. From May to September 2022 we saw that staff fell just short of 100% most months, for example, in May and September staff were 99% compliant. Our observations on inspection meant that we were not assured that the process for auditing compliance with infection control principles was always effective.

Most ward areas we visited were clean and had suitable furnishings which were clean and well-maintained. Staff completed daily check sheets to demonstrate which areas had been cleaned and to provide assurances of how regularly areas were cleaned. Supervisors checked the cleaning schedules and standards of cleaning regularly. However, some areas we saw were visibly dusty and not cleaned. One ward was seen to have discarded dressings on the floor and was dusty in some areas which suggested it had not received the same standard of cleaning as the other wards.

After our inspection, the leadership team listened to our concerns relating to infection prevention control. They told us steps would be taken to improve infection prevention control standards. They would do this by introducing an audit programme. They told us they would challenge non-compliance directly with staff. Leaders shared communication regarding the requirement to adhere to infection control standards through the Chief Medical Officer's communication network to all staff including doctors. This meant steps were being taken to monitor and improve infection prevention control compliance, however, this would need to be embedded in practice.

Staff audited infection prevention control across the division's wards. We saw monthly auditing of infection prevention control over a 6 month period and most areas were compliant. However, there were some incidences of Clostridioides difficile (C.difficile) which is a germ (bacterium) that causes diarrhoea and colitis (an inflammation of the colon). For example, on one ward there had been a total of 6 incidences over a 6 month period with 4 of those incidences occurring in October 2022. The other wards saw a maximum of 2 incidences over the same period. We saw that incidences of infection were investigated and discussed at quality and governance meetings. Learning from infection control incidents was identified and disseminated through staff newsletters and meetings. Staff said that increased movement of patients and staff between areas and wards sometimes presented challenges in managing infection control risks.

There was appropriate access to hand wash facilities and hand sanitisers agents were at all entry points in the department.

Staff audited hand hygiene compliance. We were provided with data that demonstrated overall compliance with hand hygiene across wards with an average of 100% over the period from August 2022 to October 2022.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw that 'I am clean' stickers were present where required.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept were not always managed to people safe.

Patients could reach call bells; however we saw that staff did not always respond quickly when called. We observed staff were unable to respond to call bells regularly in a timely way. Staff told us this was due to being overstretched and unable to prioritise call bell requests.

Staff did not always keep hazardous substances locked safely from reach. We saw that the COSHH (Control of Substances Hazardous to Health) cupboard door was left open and unattended. This meant that vulnerable patients on the ward could access dangerous products. We raised this with managers and staff were immediately reminded of the requirement to ensure the safe storage of COSHH items. As a result, the leadership team introduced health and safety audits to provide assurance of the safe storage of these items. The health and safety team would support staff through the audit programme and carry out spot checks. Facilities staff were directed to ensure staff on the ward undertaking their duties must ensure cupboards were locked. This was yet to be fully embedded in practice.

The design of the environment followed national guidance. There was access to separate male and female bed areas, appropriate bathing and toileting facilities. Hand hygiene facilities were easily accessible.

Staff carried out daily safety checks of specialist equipment. Staff carried out daily safety checks of specialist equipment, such as the resuscitation trolleys. Staff had scheduled calibration for equipment to ensure accurate readings. We saw evidence of these checks having been completed.

The service had suitable facilities to meet the needs of patients' families. Wards where families were permitted and there were no restrictions for example, because of COVID-19, accommodated visitors. We saw those wards permitted to have visitors were busy and staff responded to visitors when there were queries or requests for resources

The service had enough suitable equipment to help them to safely care for patients. All the equipment had appropriate safety checks in place to ensure they were suitable to use.

Staff disposed of clinical waste safely. There were a range of different waste management systems in use, which reflected safe practice and national guidelines.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient and removed or minimised risks. Staff mostly identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used the tool, National Early Warning Score (NEWS2) to assess patients. All records we saw where escalation was required was clearly recorded. Staff used a wide range of physiological assessments which were kept in patient records. For example, blood pressure, pulse, pain, and temperature. All ward areas were audited monthly. We looked at NEWS2 audit results over a three month period and saw that compliance was not consistently in line with the target. Areas for improvements were outlined with recommendations allocated to staff to action.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. All records we looked at contained appropriate risk assessment detail and involved all relevant professionals to help keep patients safe.

Medical care (including older people's care)

Staff did not always know about or deal with specific risk issues. For example, assessing patients for sepsis, Venous thromboembolism (VTE), falls and pressure ulcers. Each patient had a seven-day booklet which was reviewed daily and including a seven-day pressure area assessment, a fall prevention assessment, and a manual handling risk assessment. Each booklet was reviewed by a physiotherapist.

We saw compliance with VTE was monitored. We looked at data from April to July 2022 and saw that VTE risk assessment compliance fell outside the target of 95%. Some wards performed better than others in this area and the records we reviewed demonstrated that VTE risk assessments were completed. However, we saw that in one area compliance was below 55%. Action plans were in place and managers told us that due to changes in staffing there had been a halt to audits with a restart planned for November 2022 to improve compliance.

We were not assured that falls risks were managed effectively. Leaders monitored falls data using an accountability framework ward scorecard and this was shared at the ward monthly governance meeting. We looked at patient fall trends from November 2021 to April 2022. The data saw an increase in December 2021 and again in March and April 2022. Staff used the data to monitor across each ward. The data was broken down into bed areas, day of the week, time, there were trend comparisons and we saw themes highlighted. For example, we could see where most falls took place, and the reason for the fall.

Data provided by the trust reported 92 falls in September which was a reduction on August which was 109. Four falls resulted in serious harm. There were 16 low harm and 72 no harm incidents. This shows 5.5 falls per 1,000 bed days which is a reduction on August (6.6) and is below the national benchmark of 6.63 and above the ESNEFT (East Suffolk & North Essex NHS Foundation Trust) benchmark of 5.0.

The local benchmark has since been revised as there was no change. Our review of documentation demonstrated that for one of the wards we visited, the rate of falls was as high as approximately 20 falls per 1000 bed days. Audit data from April to September 2022 demonstrated that falls risks assessments were consistently not completed. Leaders acknowledged that lack of staffing did impact on the ability to manage falls risks effectively. Leaders had identified some actions to try and reduce the risks. For example, during our inspection, we saw that external non-clinical staff were employed where falls had been assessed as a risk. This meant that patients identified as a falls risk could receive one to one care to reduce the incidence of falls. The risk of falls featured on the divisional risk register and was discussed at board level.

Staff did not always share key information to keep patients safe when handing over their care to others. Handovers between shifts happened on every ward. We observed 3 of the ward handovers and board rounds. Staff shared detailed information which enabled them to undertake their responsibilities safely. The multidisciplinary board round we observed, provided an opportunity for each patient to be discussed in detail. This included discharge and continuing health and social needs. We saw new patients admitted with full investigations carried out, risk detail shared, for example, pressure area mentioned and managed. However, we received a number of complaints relating to discharge information not being shared with adult social care agencies in the community. This meant that all key information was not always shared to help keep people safe.

Staffing

The service did not always have enough staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers did regularly review and adjusted staffing levels and skill mix.

Medical care (including older people's care)

National shortages of nursing and support staff and elevated levels of staff absence meant the division did not always have enough staff to keep patients safe. Leaders facilitated an ongoing recruitment campaign to fill nursing and support staff vacancies. Leaders introduced several initiatives to increase nurse staffing establishment to allow for absences and vacancies so they could provide continual safe care as much as possible.

Staff we spoke with told us they were often short of qualified nursing staff and healthcare assistants. However, staff we spoke with on the night shift told us they always received their breaks and there was a staff room for them to take time out. Staff told us they felt supported by managers, however short staffing on the wards was a regular occurrence and left staff feeling overstretched and sometimes burnt out.

Staff shortages impacted on safe quality care for patients. For example, we saw nursing staff did not always respond to requests for toileting and other personal needs in a timely way. Prior to our inspection, we received concerns from patient's families, social care staff and staff who worked on the wards about the care patients received because of insufficient staff numbers.

We looked at incidents for care of the elderly wards and saw that staff had reported 112 incidents from November 2021 to November 2022. The majority were classed as no harm, but there was one moderate harm and 11 low harms. For example, staff recorded incidents where patients did not receive personal care as a result of poor staffing.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Managers relied on the use of bank staff to cover shifts. Cover at short notice often resulted in staff pulled from other wards, which then had a knock-on impact. We saw there were staff shortages across the wards on a regular basis.

We reviewed the safe staffing dashboard for the month of September 2022. We calculated an average fill rate across the month as 80%. Qualified and unqualified staff fill rates were consistently below target which meant wards were regularly understaffed most of the time. We looked at staffing levels and saw that all of the wards, except one, were short of qualified staff on days shifts for the whole month of September 2022.

Managers worked hard to adjust staffing levels daily according to the needs of patients. Managers used a staffing tool, checked three times daily, to help ensure all areas were staffed safely in accordance with patient acuity and dependency. A quality matron provided daily safe staffing oversight with a nominated deputy chief nurse or associate director of nursing to provide support at busier times.

Safe staffing meetings were held twice daily with oversight and management out of hours by the site matron. Staff were moved to balance risk to ensure wards with higher acuity and dependency were supported. Leaders worked closely with NHS Professionals to increase the pool of nurses available to respond to staffing challenges.

High demands on the wards and preparation for winter pressures meant escalation areas were planned for. A site team managed flexible rotas to increase the pool of staff available to support escalation areas. Leaders told us a substantive ward team for an escalation area was being introduced to reduce the burden on staff working in escalation areas. However, we were unclear about how they would recruit into these posts.

An additional matron for the service was introduced to offer leadership support to the senior nursing team. The matron ensured audits were completed to check standards and staff welfare was supported. A senior nursing and therapy team reviewed the initiative at the clinical programme led weekly by the Chief Nurse.

Medical care (including older people's care)

The service vacancy rates fluctuated, with an increase in vacancy rates noted trust wide. For medical care services we saw 8.6% in October 2022. The service had low turnover rates. Data provided for October 2022 were 0.96%

The service sickness rates were 6.25% in October 2022. Managing sickness was not always prioritised. This was due to supernumerary senior nurses being used to backfill to cover sickness absences. Leaders told us there were plans for sickness management to be resumed upon staffing improvements. Sickness management was recorded as a top area of focus. Actions were documented in an accountability framework document and reviewed regularly at meetings. This meant although there was regular oversight at a senior leadership level ward managers did not always have capacity to manage sickness at a local level when they were filling clinical roles.

The service used bank nurses on the wards. There had been no recent agency recruitment. Bank staff in October 2022 were at 12%. All bank staff were familiar with the service. Managers made sure all bank staff had a full induction and understood the service.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, however they were not always stored securely and easily available to all staff providing care.

Records were not stored securely. Staff did not always comply with legislation to protect patient privacy and confidential information. Patient files were kept in unlocked trolleys, this meant patient records could be accessed by individuals without permission. Leaders immediately ensured that lockable trolleys were to be purchased to ensure safe storage of patient files.

Electronic patient information was displayed on screens that could be viewed by those not authorised to do so. This was in breach of General Data Protection Regulation (GDPR). Leaders took immediate action to ensure the screens with patient details were hidden from public view. Senior staff were allocated responsibility for ensuring there were no deviations from the standard of maintaining patient confidentiality. IT support was requested to identify any further work to mitigate risk, whilst ensuring easy access for patient information in an emergency.

Patient notes were comprehensive and all staff could access them easily. Patient records were accessible in paper and electronic form. All ten patient records we looked at were completed fully with all appropriate detail. They were contemporaneous, legible, and accessible.

All staff with access to the records used unique login details. Multidisciplinary team staff contributed to patient information held in records. For example, occupational therapy staff, physiotherapists, speech and language and dietitians were included in patient record. Medical staff contributed to the records following assessments and consultant reviews. This meant detail was comprehensive and multi-professional.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff could access patient records electronically if they were permitted to do so. Staff used personal passwords to securely access patient information. Paper records were accessible when needed.

Is the service effective?

Requires Improvement ↓

Medical care (including older people's care)

Our rating of effective went down. We rated it as requires improvement.

Nutrition and hydration

Staff did not always give patients enough food and drink to meet their needs and improve their health.

Staff did not always make sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff and visitors told us, and we saw that patients who could not feed themselves did not receive support to eat all the time. Leaders responded to our concerns by reminding staff to use the 'red tray,' a visual reminder to check if the patient needs help and to confirm with a clinical member of staff. The Nutrition Steering Group also updated their agenda to support monitoring and progress, which included reviews by therapy teams in addition to senior nursing staff.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. All the patient records we looked at were fully completed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. All records we reviewed were completed fully with all relevant details.

Specialist support from staff such as dietitians were available for patients who needed it. We saw that dietitians entered information on to patient records and participated in patient meetings to provide specialist guidance and support.

Competent staff

The service made sure staff were competent for their roles. Managers did not always provide staff with appraisals to provide support and development.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. Staff received appropriate training with updates, specialist support from specially training clinicians, for example, dementia specialists and additional training where required.

Managers gave all new staff a full induction tailored to their role before they started work.

Managers could not always support staff to develop through yearly, constructive appraisals of their work. We looked at evidence provided by the trust and saw compliance at 86% completion of staff appraisals. This fell short of the expected increase to meet the target of 90%. We saw documented that managers recognised that staffing issues meant some staff appraisals were delayed due to ward sisters working clinically.

The clinical educators supported the learning and development needs of staff. All staff we spoke with were positive about the level of support they received for their personal development. For example, a healthcare assistant told us they were happy to be supported in achieving an NVQ level 3 qualification. One leader told us they were supported in achieving a leadership qualification.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We saw good attendance at meetings and information shared electronically for those unable to attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff were supported in developing their learning and development needs through one to one's with their managers, feedback through learning questionnaires and themes identified through audits.

Medical care (including older people's care)

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff we spoke with told us they were supported in their continuing professional development and with protected time, staffing levels permitted.

Managers made sure staff received any specialist training for their role. Leadership development qualifications were given to those in management and leadership roles.

Managers identified poor staff performance promptly and supported staff to improve. Managers shared examples of when performance was identified as concern and support given to make improvements.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed well attended multi-disciplinary meetings. Each containing a wide range of professionals, for example, at one we saw a consultant, five doctors, an occupational therapist, ward sister, matron, and an advanced clinical nurse (discharge team) and ward clerk.

We saw recorded meeting minutes with good multi-professional attendance. We saw various initiatives across the division where professionals from across disciplines worked well together. For example, discharge coordinators, occupational therapists, and physiotherapists all working together for the benefit of patients.

Patients had their care pathway reviewed by relevant consultants. We saw good joint working between consultants on the wards, sharing of verbal detail and written up in patient notes to ensure care pathways were appropriate for each individual patient.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. We saw staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness. All patients we spoke with told us they had been treated well. Families we spoke with told us they had observed kindness and compassion from staff. However, some staff and relatives expressed concern about having enough time to provide compassion at the standard they wanted.

Medical care (including older people's care)

Staff followed policy to keep patient care and treatment confidential. We saw conversations take place in quietly and where possible in private to maintain confidentiality.

Staff understood the individual needs of patients living with dementia. We saw one patient enjoyed a reminiscence area on a ward.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Feedback from patients and their relatives that we spoke with was that they felt supported emotionally by staff and were provided with advice to help them make sense of what was going on.

Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. All staff we spoke with demonstrated an understanding of the impact on people's wellbeing and as such were sensitive to this.

Understanding and involvement of patients and those close to them

Staff did not always support patients, families, and carers to understand their condition and make decisions about their care and treatment.

Staff did not always make sure patients and those close to them understood their care and treatment. We saw medical staff communicate with relatives sharing information prior to discharge. However, on one occasion, we saw that relatives were not updated. We shared this concern with the leadership team. Leaders told us they recognised that communication needed improvements. Leaders introduced an allocated named person to communicate with relatives prior to patients discharge to ensure they have the latest information.

Staff talked with patients, families, and carers in a way they could understand, using communication aids where necessary. There were options to use interpreters and translation applications. There were hearing loops for those hard of hearing, a range printed material in other languages if needed and visual aids.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There were various methods do this this; verbally in the first instance, electronically and in writing.

Patients gave a range of feedback about the service. We saw evidence of positive feedback and thank you cards on display in the wards. However, one matron told us there had been complaints from relatives about the poor communication between medical/nursing staff and relatives. They were working towards improving communication and saw this as a priority to help reduce concerns raised about the service.

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement.

Medical care (including older people's care)

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

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

Managers planned and organised services so they met the changing needs of the local population. The trust had recently set up an additional step down facility to help to support those patient's ready for discharge, however awaiting community provision. Leaders planned for winter pressures by introducing additional bed provision for older people. Leaders understood the need for flexibility to support the diverse needs of the local population, for example, working with the local safeguarding teams to provide additional care for the elderly.

Facilities and premises were appropriate for the services being delivered. In some areas, extra beds were set up to manage additional flow throughout the hospital. These areas were risk assessed with appropriate equipment and staff were employed from external agencies to support patient care.

Meeting people's individual needs

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

Wards were designed to meet the needs of patients living with dementia. Patients living with dementia had access to dedicated dementia friendly areas on some of the wards. Patients could enjoy music from their preferred era and memorabilia as reminders from times gone by. There was a dementia friendly sensory garden with seating area. Dementia specialists for the service supported staff in working with patients living with dementia.

Patients could access a multi faith chaplaincy which offered a range of spiritual and holistic care. The chapel, inclusive of all faiths were available, and chaplains could visit individuals by arrangement.

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

The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

An occupational therapist told us of an initiative to encourage effective discharges. They supported discharges back into the community by attending the patient's home with them and all the equipment needed to assess discharge suitability. The initiative meant that the patient's bed was kept open until the patient was assessed as appropriate for discharge. We were told that sometimes the discharges failed, and on those occasions, the patient would return to hospital in the bed kept open to avoid going through unnecessary admission steps.

Access and flow

Arrangements to admit, treat and discharge patients were impacted due to significant numbers of patients that no longer met the criteria to reside in the hospital but were unable to leave as they were waiting for access to onward care packages. However, the trust was actively engaging with system partners to address these issues.

Managers and staff worked to make sure patients did not stay longer than they needed to. However, national adult social care bed shortages sometimes meant patients remained in hospital longer than was necessary. This happens

when patients who no longer meet the criteria to reside in hospital are stranded due to insufficient resources in the community. Our review of evidence demonstrated that the length of stay for some inpatients was longer than appropriate mostly due to external factors. As of September 2022, the number of inpatients across the entire trust whose length of stay had exceeded 21 days was 119. Leaders had action plans in place to work together and with partner agencies to help discharge patients in the best way possible.

Managers and staff started planning each patient's discharge as early as possible. Each ward across the division had a discharge coordinator who worked with the team daily to manage discharges. We viewed discharge letters on the computer. They contained a brief history of the patient's medical diagnosis, investigations and treatment prescribed, list of medication, care required and any follow up of care. The discharge documentation we looked at was informative and comprehensive. However, some adult social care providers told us they did not always receive all discharge detail and documentation when they took receipt of people into their care.

The trust was aware of the discharge process being a work in progress, and that the co-ordination system was yet to be embedded.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. They did this by providing a dedicated member of the divisional discharge team on each of the wards to help facilitate discharges. Discharge staff monitored patients on their ward from point of admission. The aim of the initiative was to help reduce delays. We saw performance indicators for the "Flow for Flo" quality improvement project demonstrating early flow and discharges out of the department. Leaders told us that discharge was an ongoing concern, in part because of adult social care issues, for example, shortage of care in the community.

Is the service well-led?

Requires Improvement 

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood the priorities and issues the service faced, however, they did not always manage them well. Staff did not feel the senior leadership team were visible and approachable in the service for patients and staff.

The division was led by a director of operations, a clinical divisional management team which included a divisional director, associate director of operations and associate director of nursing. The leadership structure included a range of general managers, operational managers, matrons, and clinical leads.

The leadership team told us they understood the need to be visible and had planned regular visits to staff on the wards. Staff told us they did not always see senior leadership on the wards. However, staff did feel supported by ward leaders; matrons and senior nurses.

One ward was without consistent leadership which impacted on the overall standards of care. On this ward we saw lower standards of infection prevention control. Staff told us they did not receive the levels of leadership support required to ensure the smooth running of the ward. We shared this with the leadership team who assured us that they would seek to employ a qualified member of staff to take on this role to improve the running of the ward.

Medical care (including older people's care)

Culture

Staff did not always feel respected, supported, and valued.

Staff across the wards reported good teamwork with each other; we saw this at our inspection. However, we also saw morale was low due to the pressures of insufficient staffing and a sense of not always being supported by senior leadership. We received concerns directly from staff about a culture of feeling unable to share those concerns with leaders. Staff worked well together to benefit care and treatment for patients and those close to them. We saw good relationships between medical, nursing, and operational staff.

The senior leadership team were keen to ensure there was an improving culture of communication with staff and to support staff wellbeing. This included the introduction of support services in the form of mental health support and an in-house psychology team. However, staff told us they did not always have time to access support due to staffing pressures.

Governance

Leaders did not always operate effective governance processes.

Governance systems flowed from the wards to the Board. We saw this evidenced in a range of minutes from Board level to ward level. There was a clear governance structure made up of a divisional management team, associate director of nursing, divisional governance managers, patient safety and experience staff, and included matrons and ward sisters. However, we saw governance processes were not always robust, for example patient identifying information was on display in public areas and patient files were accessible in corridors without secure storage. Safe storage of COSHH materials and infection prevention control procedures were not always followed.

There were several regular governance meetings. A monthly executive management committee who met monthly. Monthly divisional accountability meeting, weekly divisional management meetings, monthly divisional finance and performance board, monthly divisional governance and quality board, monthly medicine board and a range of other weekly governance meetings that fed into the higher-level meetings.

Leaders used an accountability framework review for the older people's services to outline issues in the division. We saw an action log reviewed monthly, with agreed actions, deadlines for completion, updates and who was responsible. We looked at the action log up to October 2022 and saw that divisional risks were discussed; ongoing actions were agreed and continued reviews planned. We saw a joint divisional action plan focused on admission criteria, clinical oversight, discharge, communications and escalation areas and governance.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

Leaders had a divisional risk register which was reviewed monthly. Actions were discussed at a range of meetings. Senior leaders shared the top risks for the division; these included staffing which continued to be a risk. Managers we spoke with were aware of the top risks in their areas. We received a copy of the divisional risk register. The register included risk levels, the speciality, controls in place and dates for review.

Medical care (including older people's care)

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations.

Action the trust MUST take to improve:

Medical care and older people's services

- The trust must ensure staff receive up to date mandatory training; including safeguarding training at an appropriate level. (Regulation 18)
- The trust must ensure that the service has enough staff to care for patients and keep them safe. (Regulation 18)
- The trust must ensure that staff comply with infection prevention control principles. (Regulation 15)
- The trust must ensure that staff comply with legislation to protect patient privacy and confidential information. (Regulation 17)
- The trust must ensure they operate effective governance processes. (Regulation 17)
- The trust must ensure the safe and effective discharge of patients back to the community. (Regulation 12)

Action the trust SHOULD take to improve:

Medical care and older people's services

- The trust should ensure staff are provided with safe and effective communication channels with senior leadership. (Regulation 17)
- The trust should ensure that staff communicate effectively with people who use the service, those involved in their care, including families and adult social care providers.
- The trust should respond in a timely and appropriate way to the needs of patients. (Regulation 9)
- The trust should ensure staff feel respected, supported, and valued. (Regulation 17)
- The trust should ensure staff make sure patients and those close to them understood their care and treatment. (Regulation 9)
- The trust should ensure managers support staff to develop through yearly, constructive appraisals of their work. (Regulation 18)

Our inspection team

The team that inspected the service comprised a lead CQC inspector, two team acute hospital inspectors and a specialist advisor.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

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

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

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

Regulated activity	Regulation