Mid and South Essex NHS Foundation Trust

Southend University 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 well-led?	**Requires Improvement**

Our findings

Overall summary of services at Southend University Hospital

Requires Improvement 

Southend Hospital is operated by Mid and South Essex NHS Foundation Trust. The hospital provides local elective and emergency services to people living in and around the districts of Southend. Medical wards provided by Southend Hospital include elderly care, acute medical assessment, general medicine, stroke, respiratory, gastroenterology, renal, endocrinology and cardiology.

Between January 2022 and December 2022 medical care had 45,835 admissions including 25,327 day cases.

We carried out this unannounced focused inspection because we received information giving us concerns about the safety and quality of the services of medical care and older people's services. The information of concern related to the quality of care provided including patient nutrition, hydration, pressure care and the management of risks.

As this was a focused inspection, we only inspected parts of our five key questions. We inspected parts of safe, effective, caring, responsive, and well-led.

We did not inspect all the core services provided by the service 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.

How we carried out the inspection

The team that inspected the service comprised of a CQC lead inspector, 2 CQC inspectors, and a CQC specialist advisor. The inspection team was overseen by Antoinette Smith, Interim Deputy Director of Operations.

During the inspection we spoke with 35 members of staff and carried out off site interviews with the senior leaders, the services falls team and the safeguarding lead. We spoke with 14 patients and 4 relatives. We observed care provided; attended site and staffing meetings, reviewed relevant policies and documents and reviewed 20 patient records.

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)

Inadequate ↓↓

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

- The service did not have enough staff with the appropriate skills to care for patients and keep them safe.
- Staff did not always keep up to date with training in key skills.
- The service did not always manage infection risk well.
- Not all staff used equipment and control measures to protect patients, themselves and others from infection.
- Staff did not always complete and update risk assessments for each patient to remove or minimise risk. Staff did not always keep detailed records of patients' care and treatment.
- The maintenance and use of facilities, premises and equipment did not always keep people safe.
- Staff did not always support patients to receive adequate nutrition and hydration.
- Staff did not always respect patient privacy and dignity.
- Governance systems and processes were not effective in relation to staff complying with internal quality standards, improving patient care, or patient outcomes.
- Systems and processes for identifying, recording and managing risks and performance were not effective.

However:

- Leaders made sure staff were competent.
- Staff worked well together for the benefit of patients.
- Staff mostly treated patients with compassion and kindness and they provided emotional support to patients, families and carers and took account of patients' individual needs.

Following this inspection, under Section 29A of the Health and Social Care Act 2008, we issued a warning notice to the provider. We took this urgent action as we believed a person would or may be exposed to the risk of harm if we had not done so. We found that the service had deteriorated since the last inspection in July 2018.

Is the service safe?

Inadequate ↓

Our rating of safe went down. We rated it as inadequate.

Mandatory Training

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

Medical care (including older people's care)

Not all nursing staff had completed and kept up to date with their mandatory training. Information provided by the service following our inspection showed overall compliance with mandatory training was 86% against the service target of 85% compliance. Nursing staff achieved the 85% compliance target for 10 out of 12 mandatory training elements. The lowest compliance was 33% for conflict resolution high risk. Staff we spoke with told us training was available online with some courses delivered face to face.

Not all medical staff had completed received and kept up to date with their mandatory training. Information provided by the service following our inspection showed overall compliance with mandatory training was 68%. Medical staff did not achieve the 85% compliance target for any of the mandatory training elements. The lowest compliance was 17% for conflict resolution high risk and the highest was 78% for conflict resolution low risk.

Not all clinical staff completed training on recognising and responding to patients with learning disabilities and dementia. Data provided by the trust following our inspection showed that 58% of medical staff had completed mandatory training in learning difficulties and 59% had completed dementia training. The completion rate for nursing staff was 79% and 86%.

Managers monitored mandatory training and alerted staff when they needed to update their training. However, staff told us that the impact of COVID-19 and staffing levels had affected access to training.

Safeguarding

Staff had training on how to recognise and report abuse.

Staff received training specific for their role on how to recognise and report abuse. Staff were trained to level 2 in both adult and children safeguarding. Not all nursing and medical staff had completed training specific for their role on how to recognise and report abuse. Nursing and medical staff did not achieve the 95% compliance target for safeguarding adults and children training.

Information provided by the service following our inspection showed nursing staff achieved 92% compliance with safeguarding adults level 1 and 2. They also achieved 91% compliance with safeguarding children.

Medical staff achieved 78% compliance for safeguarding adults and 73% compliance for safeguarding children.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. Staff knew what constituted a safeguarding concern and followed the trust's safeguarding policies and procedures. Staff were able to give examples of safeguarding concerns that they had raised.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us they made referrals through the safeguarding team. The team were available through the hospital switchboard. Staff told us that they were very responsive and supportive.

The trust had a safeguarding lead. Staff knew how to contact the safeguarding team if they had any concerns and required support. They told us the safeguarding team members were responsive and supportive.

Cleanliness, infection control and hygiene

The service did not always manage infection risk well. Not all staff

used equipment and control measures to protect patients, themselves and others from infection. However, staff kept equipment and the premises visibly clean.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). We observed inconsistent use of PPE. For example, we observed nursing staff providing care to patients without the appropriate PPE. Hostesses and nursing staff did not always wear aprons when supporting patients with their nutritional needs. This was not in line with trust policy.

Hand hygiene audit data provided by the service following our inspection showed that medical ward staff did not always achieve good compliance with hand hygiene. Between November 2022 and On-call2, there were 3 occasions where the wards within the medical division did not achieve above 90% hand hygiene compliance. Data provided for January 2023 showed that 4 out of 10 wards failed to meet the 90% compliance for hand hygiene with two wards scoring below 65%.

On Chalkwell ward and AMU staff were not consistently bare below elbows. We noted 3 staff, one had a long sleeve top, one had a bracelet, and one had a watch on.

In 4 wards we visited we noted 8 patient's catheter bags were in contact with the floor. This put these patients at increased risk of catheter related urinary tract infections. We escalated this at the time of our inspection. Staff told us that this was because they did not have any catheter bag stands. When we returned for our unannounced inspection on 7 February 2023, we did not see any urinary catheter bags touching the floor in any areas that we visited.

Information provided by the service following our inspection showed that in the 6 months before our inspection there were 6 incidences of MRSA, 2 incidences of MRSAB and 27 incidences of Clostridium difficile Infection (CDI) within the medical wards.

All wards we visited were clean and had suitable furnishings which were clean and well-maintained.

The service generally performed well for cleanliness. Cleaning audit data for the October 2022 to December 2022 showed domestic staff routinely achieved above 95% compliance with cleaning activities across the medical wards and demonstrated that all areas were cleaned regularly.

Hand sanitisers and hand washing facilities were readily available throughout the wards, and we observed staff use hand gel and sanitisers before and after every episode of direct patient contact or care.

Staff cleaned equipment after each patient contact and labelled equipment to show when it was last cleaned. We observed staff cleaning equipment after each patient contact and labelling it with green "I am clean" stickers.

Environment and equipment

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

Patients could not reach call bells in all areas. On 2 of the wards we inspected, we observed where 7 patients did not have their call bells in reach. In addition, 1 patient did not have a call bell. This meant patients could not alert staff when they needed help. On 1 ward a patient asked us for help because they were in pain and could not alert a nurse because they did not have a call bell in reach. On our follow up inspection on 7 February 2023 call bells were in reach of all patients.

Staff did not always carry out daily safety checks of specialist equipment. On 1 ward 3 wall suction units did not have cannisters in place and the portable suction unit on the ward was not working. Staff we spoke with were unaware it was not working. This meant that in the case of a patient emergency this equipment would not be available. We escalated this to the nurse in charge who told us they would escalate to maintenance. We escalated to the senior nursing team and the portable suction unit was replaced immediately. At our follow up inspection on 7 February 2023, we did not identify any concerns with suction.

The service did not always have suitable facilities to meet the needs of patients. We observed broken facilities in a number of areas we visited. On one ward, a shower head was broken, and a second shower did not have sustained warm water meaning that patients could not use these facilities. On another ward a patient told us the shower in their bay was broken and had no hot water for the week throughout their inpatient stay. They told us they had repeatedly told staff, but nothing had been done. We escalated this at the time of our inspection and was advised that an action was in place. In another ward the accessible patient toilet door lock was broken and one of the showers was out of use. Data provided by the trust following our inspection showed there were 700 tasks outstanding completion in relation to repair of the estate and facilities at Southend University Hospital. The oldest reported task was from 6 January 2021. We are not assured that the trust had effective processes for actioning repair and maintenance of facilities and equipment.

The design of the environment did not always follow national guidance. The service did not have enough suitable equipment to help them to safely care for patients. We observed that on 3 wards the placement of full capacity beds (beds used to help improve flow in the hospital at busy times) obscured fire doors. We requested a copy of the risk assessments for the full capacity beds. The trust responded that they did not conduct individual risk assessments per ward for full capacity beds. This meant that we could not be assured that all appropriate risks to ensure patient safety had been considered before the placement of these bed. No full capacity beds were observed during our follow up unannounced inspection.

The environment and facilities were not always suitable for patients with mental health illness (please see assessing and responding to patient risk for more details).

Staff disposed of clinical waste safely. Sharps bins were dated and signed, and staff ensured clinical and none-clinical waste was disposed of correctly. Staff stored cleaning equipment securely in locked cupboards on all wards we visited.

Assessing and responding to patient risk

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

Staff did not always complete risk assessments for each patient on admission and arrival, using a nationally recognised tool, neither did they review this regularly, including after any incident. We reviewed 20 sets of records and found they were inconsistently completed. Of the records we reviewed, 2 patients did not have a completed falls risk assessment, 3 did not have bed rail risk assessments, 5 patients had not had SSKIN assessments completed and 1 did not have a Waterlow risk assessment completed. On 1 ward no patients had their weight recorded as there were no scales on the ward. When we returned for our follow up inspection all patients on this ward that could be had been weighed.

Staff completed falls risk assessments inconsistently and did not ensure all mitigations were followed. Data provided by the trust showed that in January 2023 out of 11 medical wards only 1 scored 100 compliance for the trust's falls inspection scores audit. Seven scored between 90 and 99%, 2 scored 86% and one scored 66%. Staff did not always

follow actions to mitigate the risk of patients falling. For example, we saw patients mobilising without appropriate footwear. We observed a patient being helped to the toilet with their pyjama bottoms under their feet. We were not assured that staff were aware of or accurately recording all the risks associated with the patients care, which may place patients at risk of harm.

Data provided by the trust following the inspection showed that there had been 17 falls with harm of moderate or above on medical wards between January 2022 and December 2022.

The service had dedicated falls leads and an up-to-date action plan to improve the management of falls across the service as part of their falls strategy.

Staff carried out venous thromboembolism (VTE) risk assessments and these were recorded on the services electronic patient observation system and the service set a 95% compliance for VTE completion. Information provided by the service following our inspection showed that in December 100% of medical wards met the trust target of 95% VTE compliance.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. However, despite risk assessments being undertaken, mitigations were not consistently put in place. For example, on 2 wards providing care for patients with mental ill health we observed numerous ligature points in the environment, however the wards did not have access to ligature cutters. We escalated this at the time of our inspection During our unannounced inspection on 7 February 2023, we saw that ligature cutters were available.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used the national early warning score system (NEWS2) for adults. The National Early Warning Score (NEWS2) is a system for scoring the physiological measurements that are routinely recorded at the patient's bedside. Its purpose is to identify acutely ill patients, including those with sepsis, in hospitals in England. Staff recorded patient NEWS scores on a handheld IT device, which was linked to a centralised patient monitoring system. There were hospital wide outreach services to support deteriorating patients 24 hours a day, 7 days a week.

The service carried out quarterly audits of NEWS compliance in all in-patient wards. Audit data provided by the service for December 2022, showed that out of 10 medical patients that were audited 91% were escalated appropriately according to the patients NEWS score and care plan. The service had a dedicated action plan to continue to improve.

Staff shared key information to keep patients safe when handing over their care to others. We observed the staff handover process at ward level which included key information in relation to patient care. However, we were not assured that this information translated into actions within the patients nursing and care plans as we noted inconsistent patient record keeping where staff had not completed or updated care records to ensure patients' needs were met.

Staffing

The service did not always have enough experienced nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

Medical care (including older people's care)

Nurse staffing

The service had enough nursing and support staff to keep patients safe. However, the number of experienced registered nurses (RNs) and healthcare assistants (HCAs) did not always match planned numbers. Staffing levels were reviewed regularly by leaders and resources were discussed at key meetings throughout the day to ensure staffing levels met patient needs.

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. The service used a safer staffing nursing tool to manage and predict safe staffing levels. Leaders told us that recruitment was ongoing. The hospital had a recruitment programme for overseas nurses as well as recruiting student nurses. These new staff members required additional support and time to gain experience to meet the competencies required to fulfil their role. This meant that although staffing levels were calculated, the skill mix on some wards was often compromised.

The service had reducing vacancy rates. Information shared by the trust following our inspection showed in December 2022, the vacancy rate for RN was 15%. This had reduced to 4% in January 2023. The service had recruited over the substantive number of nursing staff. Including those members of staff recruited from overseas and student nurses waiting for their registration the service were recruited over their nursing numbers by 3%.

The service had a reducing turnover rate. Information shared by the service following our inspection showed in June 2022, the turnover rate was 10%. This had reduced to 8.7% in December 2022.

The service had a low sickness rate with seasonal fluctuations. Data provided by the service showed the sickness rate for nursing staff was 4% in June 2022 increasing to 5.9% in December 2022.

Managers used bank and agency staff and requested staff familiar with the service. Information shared by the service following our inspection showed in December 2022, the service used 4% agency staff and 16% bank staff.

Medical staffing

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

Information shared by the service following our inspection showed a vacancy rate for medical staff of 28% in December 2022.

The service had reducing turnover rates for medical staff. Information shared by the service following our inspection, showed the turnover rate was 17 % in January 2022 but reduced to 12% in December 2022.

Sickness rates for medical staff were low averaging at 0.15% from January to December 2022.

Managers could access locums when they needed additional medical staff. Information shared by the service following our inspection showed consistent use of bank and agency staff. The service used 20% bank and 5.6% agency in December 2022.

The service skill mix showed a higher number of junior doctors in training and a vacancy rate of 18% amongst consultants and 39% amongst doctors.

Medical care (including older people's care)

The service always had a consultant on call during evenings and weekends. Out-of-Hours medical cover (overnight Monday to Sunday) was covered by the on-call medical consultant from 9.30pm to 7.30am, the medical consultant was contactable by the services switchboard out-of-hours days (Saturday-Sunday).

Records

Staff did not always keep detailed records of patients' care and treatment. Records were not always clear and up to date but were stored securely and easily available to all staff providing care.

Patient's medical and nursing records were not always comprehensive. The service used both electronic and paper patient records, the paper records were separated into nursing and medical records and easily accessible for staff.

We reviewed 20 sets of patient records and found that they were not always clear, up-to-date and comprehensive. Staff did not always complete risk assessments and associated care plans in the records we reviewed. For example, in 3 sets of records, fluid balance charts were incomplete, 6 sets of records showed no patient weight recorded, 3 sets of records had no bed rails risk assessment completed, 3 sets of records were not consistently legible, dated and signed. In 8 sets of records, care round documentation showed that hourly checks had been completed confirming call bells in reach where we observed that this was not the case.

Electronic records were password protected and only authorised members of staff could access them. On some wards paper medical records were stored in a lockable notes trolley. Nursing notes were stored in an open file holder outside the bays.

Following our inspection, we asked the service to provide us with their most recent record audit. The audit showed that data was submitted by a limited number of wards from September to December 2022. In January 2023 the data showed that there were inconsistencies in completing records. Two wards showed 100% compliance, 4 wards scored between 98% and 92% compliance, 3 scored 88%, 1 scored 71% and 1 scored 62%. This was in line with what we found when we reviewed records. We were therefore not assured the service was keeping consistent, up to date records.

Medicines

The service used systems and processes to safely prescribe and record medicines, but staff did not always follow process when administering medication on the ward.

The service had an up-to-date administration of medicines policy and procedure due for review in July 2024.

Staff did not always follow systems and processes to prescribe and administer medicines safely. Staff stored medicines safely on the wards we visited, medicines were stored in locked cupboards and fridges behind locked doors. However, on 2 wards we observed that the medicines trolley was left unlocked and unattended in the bay meaning that medicines could be accessed by those unauthorised to access them. We escalated this at the time of our inspection.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. There were daily multidisciplinary team meetings to assess and review patients' treatment, including their medication.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

Staff did not always learn from safety alerts and incidents to improve practice. We saw that there was inconsistent understanding of guidance in some areas. On 2 wards staff did not always secure fluid thickener granules out of reach of

patients. This was not in line with the recommendations from the patient safety alert February 2015 which required the appropriate storage and administration of thickening powder. It also required that individualised risk assessment and care planning were in place to ensure that vulnerable people were identified and protected. Staff we spoke with were not aware of this alert and No risk assessments were completed relating to the safe storage of thickener granules.

Controlled drugs (CD) were stored and managed in line with the trust's policy.

Incidents

The service did not always manage patient safety incidents well. Most staff recognised and reported incidents and near misses. Managers investigated incidents although there was a backlog of outstanding incident investigations. Leaders shared lessons learned with the whole team and the wider service.

Most staff we spoke with knew what incidents to report and how to report them. Most staff we spoke with had a clear understanding of the services incident reporting system and knew how to report incidents. The service had a policy for the Management of Incidents and Serious Incidents which was within an extended review date. Between February 2022 and January 2023, the service reported 11 serious incidents.

Leaders told us there was a challenge dealing with a backlog of incidents that still needed closure or investigation. This meant that there were opportunities for learning that may not have been identified to minimise the risk of reoccurrence of avoidable harm. Minutes from the Care Group 3 accountability meeting February 2023, stated that there were 2021 incidents overdue for closure and 62 breached serious incident investigations. There were actions in place to address this backlog. The highest number of reported incidents in December 2022 related to falls, hospital acquired pressure ulcers, discharge pressure ulcers / on admission staffing and workforce.

The service had no never events on any of the medical wards.

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

Managers and trained clinicians investigated incidents and involved patients and their families in these investigations. We reviewed 2 serious incident investigation reports which showed the service had investigated the incidents, engaged patients and relatives in the investigation process and sent duty of candour letters. The duty of candour letters provided details of what went wrong and the actions the service would take to reduce incidents of a similar nature.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff received feedback from incidents during ward meetings and the actions and findings from serious incidents were presented at the department of medicine for the elderly (DME) clinical governance group meetings.

Is the service effective?

Inadequate 

Our rating of effective went down. We rated it as inadequate.

Medical care (including older people's care)

Nutrition and hydration

Staff did not always ensure patients had enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Staff provided food and drink to patients including those with specialist nutrition and hydration needs. However, throughout our inspection we noted that not all patients on all wards we visited had access to fresh drinking water that was within reach, and they did not all have access to call bells for assistance where needed.

The service did not provide protected mealtimes on any of the wards. Leaders told us that following restrictions implemented during the COVID-19 pandemic the number of dementia support volunteers had dropped. Many of these volunteers had undertaken a role in supporting people with their nutrition and hydration. This meant that there was less of these volunteers to help support patients at mealtimes. After our inspection, the trust told us that they were re-introducing volunteers to support with patient mealtimes.

Staff we spoke with told us that staffing shortages affected their ability to meet all patients' needs and that there were sometimes delays in being able to support patients at mealtimes. Throughout our inspection we saw that patients that required assistance were not always given the support required to eat their food. For example, patients were not always sat up or had their food cut up for them.

Staff did not always complete patients' fluid and nutrition charts where needed. We did not see evidence patients were always appropriately referred to the dietitian if fluid and nutrition intake needed reviewing. During our inspection, we reviewed 20 sets of patient records and noted that staff did not always complete the patient's nutrition or hydration assessment, or the patient's fluid charts. Five fluid and food records were incomplete and not dated. Information provided by the service following our inspection showed that between 1 January 2023 and 30 January 2023, one ward achieved 100% compliance with patient nutrition and hydration records, 6 wards achieved between 92% and 98% and 4 wards achieved between 57% and 78%. We were therefore not assured that the records in relation to patient care were consistently completed, which could lead to patient harm for example, weight loss and increased risk of pressure ulcers.

Not all staff interacted with patients during mealtimes on some wards we visited. We observed the 'red tray' system in place which was used to identify patients who may need additional support with eating and drinking or a specialist diet. Patient's nutritional requirements were recorded in their patient record and above their bed so that staff could clearly identify patients in need of additional support during staff handovers. However, during our inspection we observed that not all patients who required help received it in a timely manner. For example, meals were placed out of reach and sandwich packets were not opened.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff had access to the patient malnutrition universal screening tool (MUST). Following our inspection, the service provided data from its January 2023 MUST audit showing compliance with referral to a dietitian where a patient scored greater than 2 in the MUST score. Eight out of 11 wards submitted data, 4 achieved 100% compliance, 1 achieved 92% 1 achieved 67%, 1 achieved 40% and 1 achieved 0% compliance. There was inconsistent compliance with dietician referrals meaning that we were not assured that patients received timely intervention to support their nutritional needs.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Staff told us that due to staff shortages patients sometimes had to wait longer than planned for extra support to be available. We escalated our serious concerns in relation to nutrition and hydration and the trust took immediate actions to minimise the risk. This included re-introducing protected mealtimes on wards and communications to staff.

Medical care (including older people's care)

When we returned for our unannounced inspection on 7 February 2023, we saw that mealtimes were protected on the wards we inspected. Meal coordinators were nominated for the day. The role of the meal coordinator was to ensure that all patients were ready to receive their meals and staff were aware of patients that needed help and were available to provide support. On one ward we saw that 3 volunteers were there to support patients with their nutrition needs. On 2 wards we saw that a bell was rung by the meal coordinator when protected mealtime started. We observed patients being supported to sit up and supported to eat on all wards we visited. We checked 7 meal records and all except was one completed in full. We escalated to the nurse in charge, and they told us the patient had refused food. This had been escalated appropriately and there was a plan in place for the patient.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers told us there had been an increase in the number of newly qualified and overseas nurses on working on the wards following the ongoing recruitment campaign. This meant the skills mix on wards was sometimes difficult to manage to meet the needs of the patients.

Managers we spoke with told us they gave all new staff a full induction tailored to their role before they started work. Local inductions were carried out on the wards for all agency and bank staff who worked the wards. Clinical staff told us they completed a ward induction.

Information provided by the service following our inspection showed 78% of nursing staff and 93% of medical staff had received an appraisal. Information supplied by the service following our inspection showed that 100% of nursing and medical staff had completed their professional revalidation.

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. For example, we observed nutritionists, speech and language therapists and physiotherapists working with the teams on the wards to support patients.

Staff worked across health care disciplines and with other agencies when required to care for patients. Patient records showed that service staff worked with external social care services and integrated care teams to meet the needs of patients and plan for additional services or equipment on discharge.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. We saw that risk assessments were completed.

Patients had their care pathway reviewed by relevant consultants. Our review of patient records demonstrated consultants carried out timely reviews of patient care, with management plans in place.

Multidisciplinary team working was evident on all the wards we visited, and we observed respectful interactions between the staff teams and different staff groups.

Medical care (including older people's care)

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always support patients to make informed decisions about their care and treatment. Not all staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures to limit patients' liberty appropriately.

Throughout our inspection, we found that patient records relating to Mental Capacity Act (MCA) assessments had not always been completed in full and had not been signed or dated. We identified 9 patients who staff had identified as lacking capacity but had incomplete MCA assessments in their records. For example, on one ward a patient had no MCA assessment in their care records despite frequent reference to lack of capacity throughout their medical and nursing care records and care decisions had been made based on their best interest.

Managers monitored how well the service followed the Mental Capacity Act. The service carried out an annual audit of compliance with the Mental Capacity Act in March 2022. Results showed that of 15 patients reviewed 73.3% (11 in total) of the patients audited had a mental capacity assessment and the audit team found evidence to support that an assessment was appropriate and required. A further 26.7% (4 patients) had an impairment of the mind which was an indicator of potentially requiring a mental capacity assessment for significant decisions, but the audit team did not find any evidence of a mental capacity assessment for these 4 patients.

Nursing and medical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards as part of safeguarding training. However not all staff were clear how to follow processes to ensure compliance with the Mental Capacity Act. Information shared following our inspection showed nursing staff achieved 92% compliance with. Clinical staff achieved 78% compliance.

Staff implemented Deprivation of Liberty Safeguards (DoLS) in line with approved documentation. However, the DoLS was not always renewed as required. During our inspection we identified 2 patient's DoLS records had expired even though they were still required to be in place. We escalated this at the time of inspection and staff resubmitted the DoLS application.

Following the inspection, service leads told us the trust had a process in place whereby DoLS were renewed through the hospital safeguarding lead. However, this information was not shared effectively with the ward staff and staff we spoke with were not clear regarding the process to renew DoLS. For example, on one ward a patient had an out-of-date DoLS in place but the DoLS was still required. We escalated this to staff who took actions to extend the DoLS. After our inspection, the trust supplied information which indicated that the DoLS had been extended prior to our inspection by the safeguarding lead as per trust policy. This was concerning as there had been no evidence in the patient's records and staff had not been aware. We were not assured that the process for managing DoLS was effective and that patients had their liberties deprived in line with legislation and guidance.

Staff gained consent from patients for their care and treatment. We observed staff speaking with patients and gaining their consent before delivering care or treatment.

Is the service caring?

Inspected but not rated

We inspected but did not rate caring.

Medical care (including older people's care)

Compassionate care

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

Staff were generally discreet and responsive when caring for patients. In most areas we inspected, staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff providing sensitive and respectful care in most areas we visited. However, on the Acute medical unit (AMU) one frail elderly patient communicated with us that they were in pain. The patient could not access their call bell to alert staff that they were in pain because the call bell was out of reach in its holder on the wall. In addition, we observed the patient's bedsheets to be heavily soiled with urine. We escalated this to a member of staff. When the registered nurse and health care assistant arrived to make the patient comfortable and change the bed the care was delivered in a task orientated and functional way.

We mostly observed staff introduce themselves to patients during each interaction and closed curtains when providing care for patients. However, patients being cared for in full capacity beds did not always have their privacy and dignity respected. For example, the full capacity bed on Chalkwell did not have any curtains or screens to provide privacy and dignity to the patient occupying the bed. Staff told us this was not a problem because the patient was mobile and able to access the toilet without support. We saw this patient leave their bed space to go to the toilet, and observed the patient was exposed as they had a hospital gown that was not adequately fastened at the back. When we returned for our unannounced inspection on 7 February 2023, we saw this full capacity bed had been removed.

The full capacity bed on Windsor ward was in the corridor between 2 sets of double doors. The area was a thoroughfare and felt cold to the inspectors. The patient told us that they were cold. We saw staff repeatedly walking past the patient to access the storeroom. This meant the patient did not have any privacy and was frequently disturbed. We escalated that the patient was cold, and staff gave them an additional blanket.

The full capacity bed on Balmoral ward had a mobile screen available to staff should a patient require personal care. However, staff told us this was more difficult if the additional bed capacity went up to 2 as there was no privacy for the second patient. We did not observe any full capacity beds in use at our unannounced inspection on 7 February 2023.

Patients told us staff treated them well and with kindness. During our inspection we spoke with 17 patients and 6 relatives. Most patients and relatives told us that staff were kind and they felt they were well cared for. Patients acknowledged that staff were busy but told us that the staff attended to their needs. One patient told us the staff were brilliant. Another told us that their care had been very good.

Emotional support

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

Staff generally gave patients and those close to them help, emotional support and advice when they needed it. We observed staff interacting with patients using appropriate language and checking that they had understood conversations regarding their care. Staff spoke with relatives respectfully. We saw staff speaking with families giving updates on the patients care and wellbeing as well as making telephone calls to update relatives when they were unable to attend the hospital.

Medical care (including older people's care)

Staff mostly supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Some of the wards we inspected were caring for patient living with dementia, who were at times confused or disorientated. Staff showed these patients kindness and offered support and reassurances to help them to be more settled. For example, we observed staff walking with patients.

Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. Staff demonstrated empathy for the patient and family experience and the emotional impact when a loved one is in hospital particularly when the patient lacked capacity to fully understand what was happening to them. For example, we observed staff speaking with family members to answer questions or concerns.

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

Staff made sure patients and those close to them had the relevant information to understand their care and treatment. We observed staff updating relatives with appropriate information in relation to their loved one's care and treatment. Patients and relatives told us that they were kept informed about their care.

Staff talked with patients, families and carers in a way they could understand. We observed staff talking to relatives when they were approached for information and communicated appropriately. They gave patients and relatives the opportunity to ask questions and ensured that they understood the information.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service had a dedicated patient experience team, patients and relatives could leave feedback through speaking to the staff team directly or by completing the friends and family test after discharge. Patients and relatives could also use the web forms on the

Patients mostly gave positive feedback about the service. For example, information from the services friends and family test (FFT) showed that in December 2022 on Eleonor Hobbs ward 80% of 10 respondents reported a positive experience positive, on AMU 76% positive experience from 34 respondents and Chalkwell ward 75% positive from 8 respondents.

Is the service responsive?

Inspected but not rated

We inspected but did not rate responsive.

Meeting people's individual needs

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

Staff made sure patients living with mental health conditions, learning disabilities and dementia received the necessary care to meet all their needs. The service provided one to one support for patients with additional needs. We saw that

most of the staff were engaged with patients, actively supervising them or engaged in activities, for example walking with them around the ward area. However, one patient told us that their overnight one to one support spent a lot of time sleeping and we observed another one-to-one support member of staff wearing headphones and not engaging with the patient they were supporting.

Wards were designed to meet the needs of patients living with dementia. We saw that a number of wards had adaptations to help patients living with dementia, for example dementia friendly signage. Staff had access to a range of sensory distraction resources, for example twiddle muffs which could be given to patients to distract any harmful patient behaviour. On one ward colouring books had been provided to a patient who was distressed to help them focus and remain calm.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service had access to a translation serves via a phone application that could help communication where a patient's first language was not English.

Staff had access to communication aids to help patients become partners in their care and treatment. This included pictures and symbols and a phone application which could be used for translation services.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure patients could access services when they needed and received treatment within agreed timeframes and national targets. Between February 2022 and January 2023, the services bed occupancy average was 93.6%. Information provided by the service following our inspection showed that between January 2022 and December 2022 medical care had 32,663 admissions including 16,912 emergency admissions. Performance in relation to referral to treatment (RTT) within 18 weeks for admitted patients had improved from 77% in June 2022 to 81% in December 2022.

Managers and staff worked to make sure patients did not stay longer than they needed to. Information provided by the service following our inspection showed that the average non -elective length of patient stay between January 2022 and December 2022 was 7.9 days and elective 6.1 days for elective patients. The service had a dedicated site team and flow coordinators that worked alongside ward staff and with external agencies to improve patient flow and monitor discharge times.

Managers monitored patient moves between wards. Information provided by the service following our inspection showed that between January 2022 and December 22, 3305 patients were moved ward between the hours of 10pm and 6am of which 358 were patients under the care of geriatric medicine. Between January 2022 and December 2022, there were 11,015 ward moves.

Managers and staff started planning each patient's discharge as early as possible. The service had an up-to-date management of discharge policy to promote the safe and timely discharge of all patients admitted to hospital. Managers monitored discharge performance and staff were encouraged to report any delayed discharges. The service aimed to discharge patients before 11am on the day of discharge and completed a comprehensive discharge summary to support the discharge process.

The service conducted a daily “market place” meeting that had been introduced to support discharges. The meeting was overseen by a senior leader and was supported by a patient flow manager and a member of the discharge team. Ward staff attended and reported on their planned discharges and highlighted patients where there were barriers to discharge. This could then be escalated and where possible action taken to discharge patients in a timely way and improve flow in the hospital.

Managers worked to minimise the number of medical patients on non-medical wards. Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards (Outliers). Patients that were being cared for outside of a specialty were seen by the consultant on the ward where they were residing. The service had a senior member of the medical team responsible for oversight of any patients being cared for outside of their specialty ward. Information provided by the service following our inspection showed that at the time our inspection there were 53 outliers on 24 January 2023. The number of medical outliers was on the risk register.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. Patients and relatives, we spoke with knew how to make a complaint. The service had a dedicated patient experience team, patients and relatives could also leave feedback through speaking to the staff team directly or by completing the friends and family test after discharge. Patients and relatives could also use the web forms on the services web page to share their experience or use the patient advice and liaison service (PALS) or complaints services to share their experience.

The service did not clearly display information about how to raise a concern in patient areas. We did not see any complaints information displayed on the wards we visited. Staff explained that much of the written information and leaflets had been removed during the COVID-19 pandemic due to infection prevention and control, but they were in the process of bringing these documents back onto the wards.

Staff understood the policy on complaints and knew how to handle complaints. Staff we spoke with were aware of the complaints policy and told us that managers encouraged them to deal with complaints at the time where possible to resolve concerns.

Managers investigated complaints and identified themes. Information provided by the service following our inspection showed that between January 2022 and December 2022, the service received 68 complaints in relation to its medical wards. Key themes from complaint investigations included lack of communication, discharge planning and clinical treatment.

There were delays in responding to formal complaints. Data shared by the trust following our inspection showed that 30% of complaints for care group 3 were handled on time against a target of 70%.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff we spoke with knew how to deal with a complaint and aimed to resolve these as soon as possible without them having to go through the formal process where possible.

Medical care (including older people's care)

Is the service well-led?

Inadequate 

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

Leadership

Not all leaders had the skills and abilities to run the service. They did not always understand and manage the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Ward management had a clearly defined structure, with lines of accountability, roles and responsibilities. Medical wards fell under care group 3 in the managerial structure and nursing services were led by a director of nursing who reported to the chief nursing officer. They were supported by 2 deputy directors of nursing. Two associate directors of nursing led a team of matrons across the wards, supported by a nurse in charge on each ward. The deputy chief medical officer led medical provision supported by a clinical director of general medicine and local services, with 4 clinical leads.

When we spoke with the leadership team, they explained the complexities and changes in structure that followed the merger of the trust and the alignment of medical care services across all 3 sites. The team were aware of the current challenges across the service, including staffing levels, embedding governance processes and the leadership structures. Most ward staff we spoke with told us that they were supported by their local leadership team at ward manager and matron level. They felt that they could approach their managers to raise concerns and were supported to do so. However, 4 members of staff told us that senior leaders were not always supportive and approachable and were only visible on the ward when there was a problem.

Managers and leaders told us that they were coping with increased numbers of patients with increasingly complex needs and that the COVID -19 pandemic had taken a toll on the staff, which they were still managing. Leaders told us that staffing levels and skill mix due to the increased number of overseas nurses and the lack of additional multidisciplinary staff did have an impact on the patient experience. Several of the local leaders were new in post and still learning and gaining experience in their roles.

The leaders were not always clear about the risks, issues and challenges in their service. For example, leaders were not aware of the challenges some wards faced accessing the online audit system, and the maintenance backlog.

Vision and Strategy

The service had a vision for what it wanted to achieve and were developing a strategy to turn it into action.

The services clinical strategy is called ‘Your care in the Best Place’, this has been in place since 2018. The clinical models developed as part of this strategy included medical specialties: cardiology, respiratory, renal medicine, stroke and other specialities.

Following our inspection, the service told us that medical specialties would be working on developing their individual clinical strategies in the next 12 months. The local services purpose was to provide a safe and caring service to patients, develop an environment that encouraged growth of staff and an unrelenting focus that kept the patients they cared for at the centre of their work on a daily basis.

Medical care (including older people's care)

The service had a set of values including: Excellent, we go all-out for excellence and put delivering exceptional care at the heart of everything we do. Compassionate, we act with care and compassion toward ourselves, patients, colleagues and our communities. Respectful, we appreciate the value of each other and nurture positive relationships. We ensure all voices are heard and respected.

Within local services they had 8 strategic priorities which were focused on keeping patients safe, improving the quality and access to care for patients, promoting respectful behaviours, engagement and partnership working.

Culture

Most staff felt respected, supported and valued and felt the service had an open culture where patients, their families and staff could raise concerns without fear. However, some staff felt that senior leaders did not always listen and were only visible in the service when things went wrong.

Most staff we spoke with told us they felt respected and valued by local managers. However, some staff told us that there was not a positive, open culture. They told us that senior leaders (executive level) were not always supportive or constructive in their challenges and were only visible in clinical areas to raise concerns or question actions.

Staff were passionate and committed to delivering patient-centred care. However, staff told us they were very tired. They told us that the COVID 19 pandemic had been an extremely challenging time but in some ways, there were more challenges currently and that they were not yet at the end to the challenges they were dealing with. Staffing levels and the increased complexity of patient needs had contributed to low morale amongst some of the staff we spoke with. Some staff were visibly emotional when they shared this with us.

Volunteers providing additional support to patients living with dementia or additional care needs were no longer visible on the wards. A lot of volunteers had stopped working during the pandemic and had not returned. Staff and senior leaders told us there was a strong focus on capacity and flow and push to discharge patients to provide more bed space to ease pressure in the emergency department and on the ambulance service. This had impacted on culture on some wards including the acute medical unit (AMU) This meant that the culture was more performance driven than patient centred with focus on fundamental care. This was also impacted by the ongoing challenge of recruiting healthcare assistants who were key in providing holistic, safe care for patients.

Many of the staff we spoke with had worked for the service for many years. They described it as good place to work but had noticed changes in recent years due to the challenges the service faced. They told us that the ongoing staffing issues impacted the culture and the constant moving of staff to cover in different areas due to staff shortages impacted morale, wellbeing and teamwork.

Governance

Leaders did not always operate effective governance processes throughout the service.

The service had governance structures, which they described as a ward to board process, sharing information and risk from ward level operations to board level oversight. Ward and departmental meetings fed into speciality meetings, then the divisional board, care group board governance and governance subgroups. These groups fed upwards to the board sub committees, quality governance committee and then the services board and met on a monthly basis. However, we noted a lack of compliance in a number of areas related to patient safety and risk across the service, for example the completion of patient records and managing risks, concerns around the estates and the safety of environments where patients with mental health concerns were cared for. When we escalated these concerns, senior staff were not always

aware of the issues. We were not assured that governance systems and processes were effective in relation to senior leadership oversight of staff compliance with internal quality standard to meet patients' needs and keep them safe. The electronic audit process was not robust. Data was not consistently submitted from all ward areas due to difficulty accessing the online system.

We reviewed the local department of medicine for the elderly (DME) governance meeting records from October, November and December 2022, which showed that staff discussed quality and performance to identify any emerging risks and review existing risks across the service. Areas covered included incidents, staffing mix and levels, harm free care, falls, pressure ulcer prevalence and shared learning and other key information.

Management of risk, issues and performance

Leaders and teams used systems to manage performance, but these were not effective. Risks were not always identified and escalated, and actions were not always taken to reduce their impact.

The service had systems and processes for identifying, recording and managing risks, issues and mitigating actions but these were not effective or fully embedded.

The service had an up-to-date risk register, that included risks in relation to increased number of pressure ulcers, recruitment and staffing levels and patient flow alongside other areas of risk. Leaders and managers, we spoke with were aware of the services recorded risks and which risks related to their respective areas. Risks were reviewed at the monthly governance team meetings.

One of the risks added to the risk register in August 2021 related to concerns regarding bathrooms and ligature points in the AMU. Although the actions in place noted that a standard operating policy had been implemented relating to the care of mental health patients in this area no action had been taken to address the concerns regarding the environmental risks. We were therefore not assured the service had oversight that the environment was safe for people experiencing acute mental health illness.

There were over 700 tasks outstanding completion in relation to repair of the estate and facilities. The oldest reported task was from 6 January 2021. During our inspection, service leaders told us they had no way of monitoring when tasks had been reported, escalated or completed. We did not see that this was on the service risk register.

The service had a local ward electronic audit system to capture performance and risk data at ward level, however not all wards had reliable access to the system. When we reviewed audit data submitted from November 2022 and December 2022, we saw inconsistent data from the ward areas. Two ward managers told us that they could not always access the system to submit data, and another told us they had not been able to access the system at all. We saw that audit data submission had improved. However, during our inspection we noted inconsistencies that should have been identified and acted on through the internal audit system. For example, staff not completing patient fluid and nutrition records and managing falls risks and pressure care. We were not assured that leaders could effectively monitor and ensure that staff were complying with internal quality standards, improving patient care, or patient outcomes.

Areas for improvement

MUSTS

- The service must ensure that all staff complete mandatory training. (Regulation 18 - (1))

Medical care (including older people's care)

- The service must ensure that maintenance is completed in a timely manner and that estates are maintained to keep patients and staff safe. (Regulation 15 - (19e))
- The service must ensure that all staff complete patient records to ensure they are accurate, up to date and legible and that all risk assessments are completed to maintain patient safety. (Regulation 17 - (1(c))
- The service must ensure that staff follow the services administration of medicines policy and ensures that medicines are secured appropriately when administering patient medication. (Regulation 12 - (1(g))
- The service must ensure always follow infection control principles including the use of personal protective equipment (PPE). (Regulation 12 – (1-2 (h))
- The service must ensure that mealtimes for all patients promote the opportunity for them to eat and drink safely and ensure that staff meet patients' nutritional and hydration needs, having regard to the patient's well-being (Regulation 9 – (1(h) (i))
- The service must ensure it has effective governance, risk and performance measures in place. (Regulation 17 – (1-2 (a) (b) (c))

Shoulds

- The service should ensure that staff take measures to protect the dignity of patient in full capacity beds. (Regulation 10 – (-2(A))

Our inspection team

The team that inspected the service comprised of a CQC lead inspector, 2 CQC inspectors, and a CQC specialist advisor. The inspection team was overseen by Antoinette Smith, Interim Deputy Director of Operations.

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
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury Surgical procedures	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

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

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	S29A Warning Notice
Surgical procedures	
Treatment of disease, disorder or injury	