University Hospitals Birmingham NHS Foundation Trust

Good Hope Hospital

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Good Hope Hospital

Inspected but not rated

Medical Care at Good Hope Hospital - Overall rating: Requires improvement

Good Hope Hospital is operated by University Hospitals Birmingham NHS Foundation Trust. Good Hope Hospital predominantly serves the areas of Sutton Coldfield, North Birmingham and a large proportion of south east Staffordshire. The catchment area is approximately 450,000. The medical core service spans across 4 divisions at the trust (divisions 2, 3, 4, and 7).

We conducted an urgent, unannounced inspection of the full medical care core service due to a number of concerns raised by patients and their families around the care and treatment they had received. We also observed a number of serious incidents and safeguarding concerns in relation to the services provided by the medical core service.

Our rating of medical care at Good Hope Hospital stayed the same. We rated it as requires improvement because:

The service did not have enough staff to care for patients and keep them safe. Compliance with some key training modules was low. The service did not always control infection risks well.

Staff did not always assess the nutritional risk of patients accurately which impacted on the support required. Concerns were raised over how staff worked together for the benefit of patients.

The service was significantly challenged due to demand which meant people could not always access the service when they needed it and in a timely manner.

The culture of the service had deteriorated and morale amongst staff was noticeably low. Staff did not always feel respected, supported and valued. There was variable feedback about the leaders who ran services.

However:

Staff understood how to protect patients from abuse, and managed safety well. Staff assessed most risks to patients, acted on them and kept good care records. They managed medicines well. The service mostly managed safety incidents well and learned lessons from them.

Staff gave patients gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff advised patients on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.

The service planned care to meet the needs of local people, and mainly took account of patients' individual needs, and made it easy for people to give feedback.

Our findings

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.

Staff used reliable information systems. Staff understood the 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.

Following this inspection, we issued the trust with a Section 29A Warning Notice as we found significant improvement was required in relation to safe staffing of the service. The Section 29A Warning Notice has given the trust until 15 March 2023 to make the significant improvements we have identified.

Medical care (including older people's care)

Requires Improvement 

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, however there were a number of elements which had compliance rates below the trust target.

The mandatory training was comprehensive and met the needs of patients and staff. However, not all staff received and kept up to date with their mandatory training. Information received after the inspection showed in December 2022 there was an overall compliance rate of 84% for mandatory training compliance against a trust target of 90%. This had declined since the previous inspection where the overall compliance was recorded as 90%. There were some topics which were above the trust target of 90%, this included inclusion and diversity, manual handling theory, resuscitation awareness and safeguarding children and adults level 1. However, there were topics which were well below the target including essential skills for example manual handling patient handling, infection prevention and control level 2 and resuscitation (clinical life support). Compliance for these topics ranged from 58% (infection prevention and control) to as low as 46% for clinical life support. This was significantly concerning due to the potential consequences on patients who deteriorated during their admissions. Information collated after the inspection highlighted the need to increase overall compliance for mandatory training, however there appeared to be no deep dive into the modules which the service were significantly challenged against to enable detailed plans to be implemented. This meant the service were unable to identify the challenges impacting those modules and thus inhibited actions to rectify them.

Staff told us they had previously completed basic level training on recognising and responding to patients with mental health needs, learning disabilities, autism or dementia. However, information requested after the inspection did not identify that staff completed essential training for patients with mental health needs, learning disabilities or autism. Information showed that dementia positive approach training had been implemented to support staff who cared for patients living with dementia. Information showed 70 members of staff out of the complete staffing for the service had so far completed this.

Staff told us they were currently admitting more patients who had mental health needs and at times staff were required to restrain them. Staff told us they did not feel adequately trained to manage these patients, although security staff took the lead on the restraint of patients. However, staff told us, they were expected to manage these patients until security staff arrived and would be required to help at times. Staff completed conflict resolution training to aid de-escalation of challenging situations, however the trust did not provide restraint training for clinical staff. Information received after the inspection showed the trust were scoping the training needs for staff in relation to patients who had complex and mental health needs.

Medical care (including older people's care)

Managers monitored mandatory training and alerted staff when they needed to update their training. However, staff were currently experiencing pressures within the ward area which meant they were not always able to attend face-to-face training. If staff completed their electronic training outside working hours, they were required to record this to enable them to get their time back. However, staff told us this was not always possible due to ongoing demands and challenges.

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.

All staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were aware of relevant safeguarding policies which were based on national guidance and legislation and followed them if they had concerns. The trust had a safeguarding team who were in the process of merging with the vulnerabilities team. Staff told us they were visible and approachable.

Staff received training specific for their role on how to recognise and report abuse. Staff were required to complete safeguarding adults and children training (level 1 and 2) as well as separate PREVENT and safeguarding (Mental Capacity Act) training. Information received after the inspection showed overall compliance for all relevant safeguarding topics ranged between 83% and 100%. PREVENT level 3 and safeguarding adults and children level 2 had the lowest recorded overall compliance of 83% and 86% respectively. Although this was slightly below trust target, this did not appear to impact staff knowledge on what constituted abuse and neglect and how to act on concerns.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff discussed examples of safeguarding concerns they had identified, and actions taken to ensure patients were safe.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff gave examples where they had contacted the trust safeguarding team to discuss concerns over patients who were admitted and submitted referrals to the local authority to raise their concerns. This included patients who were admitted with mental ill health. Where additional support was required due to safeguarding concerns, staff also contacted the mental health trust who provided support. Staff produced detailed plans to help support patients, which also included requesting registered mental health nurses to provide support for patients with specific needs.

Children were rarely permitted to attend the medical wards for visiting except in special circumstances. In those rare, special occasions, staff followed safe procedures for children visiting the ward.

Cleanliness, infection control and hygiene

Staff did not always control infection risk well. However, staff used equipment and control measures to protect patients, themselves and others from infection and kept most equipment and the premises visibly clean.

Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. All wards and departments visited during our inspection were visibly clean. However, we did observe some boxes stored on the floors in the storerooms which would have prevented staff from thoroughly cleaning these areas.

Medical care (including older people's care)

The service generally performed well for cleanliness. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Information received after the inspection showed all areas which were included in the medicine core service achieved between 94% to 99% for their cleanliness on the most recent cleanliness audits. The average compliance across all areas was 97% for cleanliness. All areas apart from the female and male Acute Medical Unit (AMU) were classified as high-risk areas which meant they required a cleanliness compliance score of 95%. The female and male AMU were designated as very high-risk areas and they required 97% compliance with cleanliness.

At the time of our inspection, there were 2 wards closed due to infection prevention and control (IPC) reasons. This was due to an increase in the numbers of COVID-19 patients and was in line with trust policy.

Staff completed IPC risk assessments for all patients on admission. The trust's electronic patient records system had an alert to highlight any previously known infections which patients had tested positive for. This ensured patients who were infectious were admitted into a correct bed space and not placing other patients at risk. During our inspection, we were aware of 2 patients who had attended the Medical Assessment Unit (MAU) who were confirmed to be positive for Influenza. Unfortunately, these patients were in a communal area which meant other patients had been put at risk of contracting Influenza. These patients were later moved to areas which only had screens in place. This did not completely reduce the risk of other patients contracting this. We raised this as an area of concern with the trust.

Information received after the inspection showed between November 2021 and November 2022, there had been 2 MRSA bacteraemia's, 10 MSSA (Meticillin sensitive *Staphylococcus aureus*) bacteraemia's, 31 *Escherichia coli* bacteraemia's and 33 *Clostridioides difficile (C. difficile)* infections within the medical service at this location. All infections were taken seriously, and reviews took place to ensure any opportunities for learning were implemented. Senior members of staff acknowledge this site was challenged in relation to IPC measures (for example, there were lower numbers of single patient rooms for isolation purposes at this location). It was observed that the number of MRSA bacteraemia's reported at this location accounted for a third of all trust MRSA bacteraemia's in this time frame.

Staff mostly followed infection control principles including the use of personal protective equipment (PPE). All wards had an adequate supply of PPE for staff, patients and visitors to use. We observed most staff wearing appropriate PPE for the tasks they were completing. Staff also asked patients and visitors to wear masks if they were able to. However, we did observe some staff wearing masks which had slipped down off their nose which presented an infection risk.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. However, we observed some items of equipment which had dust present despite labels advising they were clean. This therefore meant items were no longer clean and ready for the next use. The service did not have an appropriate system to ensure all equipment remained clean and ready for use.

Endoscopy equipment was reprocessed on site. The service had 4 drying cabinets to ensure the swift reprocessing of the endoscopy equipment. Staff undertaking this task had completed competencies to enable them to complete this.

Environment and equipment

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

Patients could reach call bells and staff responded quickly when called. Most patients were observed to have their call bells near to them to call for assistance if required. We also observed call bells appeared to be responded to quickly despite significant staffing challenges across the wards.

Medical care (including older people's care)

The design of the environment followed national guidance. Wards and departments were designed in accordance with Department of Health guidance Health Building Note 04-01: Adult in-patient facilities and included for example, appropriate patient and staff facilities to keep people protected from avoidable harm. However, we did observe an area of concern in relation to a blocked fire exit and restricted access to a patient's side room due to the storage of equipment on Ward 23. We raised this as a concern at the time of our inspection and staff immediately rectified this. Staff told us this was a common area of concern which they had also escalated previously but continued to occur.

Information received after the inspection showed the service had considered the risks which the environment presented to some patients with mental health needs. Ligature risk assessments had been completed on all areas due to the increase in the number of patients who were admitted with mental ill health. Where potential risks were identified, the author of the risk assessment had identified remedial actions to take to reduce the risk.

Staff mostly carried out daily safety checks of specialist equipment. We observed some gaps within the checks of resuscitation equipment on most ward areas. This meant that resuscitation equipment may not be ready for use in the event of an emergency. However, staff were aware of this and this was being addressed locally with regular reminders during safety huddles and stricter oversight by ward managers. We reviewed a selection of clinical consumable items including but not limited to cannulas, dressings, airways, suction tubing, syringes and blood sample bottles and found all items were in date.

The service had enough suitable equipment to help staff to safely care for patients. All staff we spoke with told us they had adequate amounts of equipment to enable them to complete their jobs.

Staff disposed of clinical waste safely. We observed staff correctly segregating clinical and domestic waste. Waste bins were enclosed and foot operated. Sharps bins were correctly assembled and below the fill line. The management and disposal of sharps and waste was completed in accordance with the trust policy.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and mostly identified ways of removing or minimising risks. However, staff were not always able to implement measures to reduce the risk of harm to patients due to staffing restrictions. Staff identified and acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The hospital used the National Early Warning Score 2 (NEWS2) for the detection and response of deteriorating patients. We reviewed 32 records for patients admitted within the medical wards or under the care of medical specialities and found observations were completed according to the frequency required for the patient. Staff inputted the observations into the electronic system and this calculated the NEWS2. When patients scored outside of the acceptable parameters, an alert was placed on the system which staff accessing that patients record would see. However, this did not automatically send an alert to the medical staff caring for the patient to indicate a review was required. This meant nursing staff needed to escalate any concerns to the medical team. On the day of our inspection, we observed patients who had previously scored high on the NEWS2 and the alerts in relation to these scores were still showing up on the electronic records system (one example included a patient who had scored a high NEWS2 4 days prior to our inspection). We discussed with staff what actions would be expected and how they would know the patient had been reviewed. Staff were knowledgeable about the actions required if they identified a patient with a high NEWS2 and were able to

demonstrate where staff would document once they had seen a patient following a high NEWS2. However, not all staff were able to explain why some patients continued to have alerts showing for scores they had previously recorded and accepted this could appear confusing. At the time of reviewing the system, there were no patients who had a new high NEWS2 which required escalation

Staff completed risk assessments for each patient on admission / arrival, using recognised tools, and reviewed these regularly, including after any incidents. These risk assessments included but were not limited to a patient's risk of skin damage, malnutrition risks, manual handling and falls risk. All risk assessments were located on the electronic patient records system used by the trust. This prompted staff when risk assessments were due to be completed again. We reviewed the risk assessments completed for 32 patients and found the majority of them were completed within the expected time frame. Where action was required, for example a patient at risk of developing pressure damage needing equipment to reduce this risk, there was evidence of this being completed for most patients.

However, we had concerns over the malnutrition risk assessments staff completed. We found concerns for 6 records where staff had calculated the malnutrition to be low despite the patient condition identifying concerns, no weight was recorded (or an estimated weight was recorded for a patient which was not appropriate as the patient could be weighed) or previous high malnutrition risk with no change in the patient's condition. We also found concerns where patients were not referred to dietitians despite their malnutrition risk assessment identifying them as requiring a referral. We discussed our concerns with a member of the dietetic team who was aware of concerns over accurate malnutrition risk assessments and were conducting targeted training to improve this concern. The service used a clinical dashboard to monitor compliance with a range of clinical indicators including the malnutrition risk assessment. Information showed the average compliance with the completion of malnutrition risk assessments between July and November 2022 was 57%. Wards 8, 11 and 14 recorded the lowest compliance with malnutrition risk assessment, with an average of 38%, 34% and 37% respectively.

Staff received sepsis awareness training and completed sepsis screening for patients when concerns were raised. Staff had access to point of care testing facilities which now included lactate testing which is a key component of the 'Sepsis Six' bundle. There is strong evidence that the prompt delivery of 'basic' aspects of care detailed in the Sepsis Six bundle prevents much more extensive treatment and has been shown to be associated with significant mortality reductions when applied within the first hour. At the time of our inspection, there were no patients who were showing signs of potential sepsis. The trust monitored their own performance against the sepsis bundle. The audit completed between June and November 2022 identified the medical divisions achieved 100% compliance with commencing antibiotics within 60 minutes of suspected sepsis diagnosis. However, only 51% of patients had blood cultures obtained. It is a key part of sepsis management to obtain blood cultures prior to administering antibiotics to enable staff to comply with antimicrobial stewardship and ensure patients receive specific treatment for their infection. The service had an action plan in place to improve compliance with blood cultures and many quality improvement projects were in place to improve this standard.

Staff knew about and dealt with many specific risk issues. However, in many ward areas staff told us about their concerns over the number of falls and patients with pressure damage due to staffing pressures preventing them from taking appropriate, preventative action. On the first day of our inspection, staff reported that they had unfortunately had 2 patients fall due to being unable to provide the supervision the patients were assessed as requiring.

Patients who required non-invasive ventilation were allocated a bed on the Respiratory Ward (Ward 24). Non-invasive ventilation (NIV or 'mask ventilation') is a way of helping a person to breathe more deeply by blowing extra air into the lungs via a mask when they breathe in. This ward had 6 beds allocated for patients requiring NIV and was physiotherapy led with nurses working alongside them who had completed additional competencies to care for these patients. Staffing

was always ring fenced for this ward due to the requirements for safe staffing when providing the treatment. British Thoracic Society guidelines state patients being initiated on NIV should be identified as requiring level 2 care and have increased nurse staffing levels that equate to 1:2 nurse to patient ratio for the first 24 hours. Staff ensured this occurred for those patients who were within the first 24 hours of NIV treatment.

Patients undergoing endoscopy procedures and procedures in the cardiology department had checklists completed which incorporated an adapted World Health Organisation (WHO) Surgical Safety Checklist and locally adapted safety standards for invasive procedures (LocSSIPS). We saw evidence staff had completed these checklists well.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). However, we did not observe ward staff completing any mental health risk assessments for patients thought to be at risk of self-harm or suicide. We observed patients who had been referred and subsequently reviewed by the specialist mental health team, especially where there were concerns around their safety to themselves or others. Staff all spoke positively about the support they receive from the specialist mental health team and the timeliness of reviews when they had referred patients.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. Due to the concerns over staffing and the high acuity of patients, we observed a handover occurring in the middle of a ward. Whilst all information was handed over, there were concerns over confidentiality. A patient who was in the side room overheard information and became concerned as they believed this to be about them.

Safety huddles were also conducted after handover where specific safety issues were identified, and actions assigned to staff to ensure the safety of the ward. This included but was not limited to identifying time critical medications which required administration, patients requiring enhanced care and the task of checking the resuscitation equipment. This was recorded in a book at the nurses' station.

Staffing

Nurse staffing

The service did not have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, however they were not always able to amend staffing levels to meet the needs of the patients on the wards. Bank and agency staff received a full induction.

The service did not have enough nursing and support staff to keep patients safe. During our inspection we found most wards were operating below national guidance for safe staffing levels. The Royal College of Nursing recommend safe staffing levels of 1 qualified nurse to 6 patients. Staff told us shifts were regularly planned for 3 qualified members on staff each shift, however this regularly reduced to only 2 qualified staff members working on the shift. Even with 3 qualified nurses on each shift, this would still have been outside of the recommended safe staffing levels. On the 13 December 2022, we found Ward 16 which had medical outlier patients admitted at the time were reduced to 1 qualified member of staff for 26 patients, at the time of our visit. The registered nurse was supported by a trained nursing associate. On the 13 and 14 December 2022, we found Ward 9 had a ratio of 1 nurse to 17 patients on both days of our inspection. Staff told us the ward had a high acuity as they had a large number of patients with complex needs, many of

whom required 1:1 supervision. At the time of our inspection, staff were unable to provide this due to the unsafe staffing levels. On the first day of our inspection, Ward 9 reported 2 falls as they were unable to provide the 1:1 support for them. One patient did not sustain serious harm, however, 1 patient was awaiting a head CT scan and undergoing neurological observations due to the fall. Staff told us this was not a rare occurrence due to the challenges they faced with staffing.

We raised our concerns about staffing during and after our inspection and issued the trust with a Section 29a Warning Notice advising them of timely improvements needed to be made due to serious safety concerns.

We requested staff rotas for all medical wards and Ward 16 where known medical outliers were admitted and where concerns had been identified for December 2022. We found shifts were varied as to the number of qualified staff due to work. Over the Christmas bank holiday period, staffing appeared much improved in most wards. However, there were a number of shifts where 2 or less qualified staff were identified to work, which was well below the recommended safe staffing levels within wards and placed patients at risk of potential harm and poor care due to not having their needs met. We were aware these rotas did not take into account any agency staff members may have been confirmed to work.

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. However, due to staffing pressures, the number of nurses and healthcare assistants rarely matched the planned numbers. We found a number of wards which had not completed the board which displayed the planned and actual staffing numbers.

The ward manager or nurse in charge tried to adjust staffing levels daily according to the needs of patients. Where staffing levels were low and patient acuity was high, managers would escalate their concerns to the site team who would try to re-deploy staff to make the area safe. However, staff told us there were not always staff to move to other wards and often when staff were moved, this left the ward they were leaving short staffed.

The service had significant vacancy rates. Information received after the inspection showed for December 2022 there was a vacancy rate of 78.06 whole time equivalents (WTE) across the medical services for qualified nurse staffing. There was an additional vacancy rate of 15.36 WTE for healthcare assistants. The service had plans to continue with recruitment campaigns to improve the staffing for the service at this location. Targeted recruitment campaigns had also been completed in the past at this location. However, there were no timeframe for how quickly this would improve the staffing concerns within the service.

The service had an average turnover rate of 13.53% between December 2021 and November 2022. The trust did not have a target for the turnover of staff, however the average turnover rate for the whole of the trust was 12.67%. There were some speciality services within medicine which had lower turnover rates (for example stroke services) however, most services had higher than average turnover rates, with acute and short stay medicine recording the highest at 19.88%.

The service had an average sickness rate of 7.83% between December 2021 and November 2022 which was higher than the trusts long term sickness target. However, information showed the sickness rates fluctuated during this time. Some areas reported a sickness rate of 0% for a number of months (for example Ward 8 and Ward 20 Short Stay Medicine). There were a number of wards that recorded high sickness rates throughout the 12 months (Wards 8, 10 and 14 had higher levels of sickness throughout).

Managers did not limit their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service. Where possible, managers tried to ensure the same agency staff were booked on to wards to ensure familiarity and consistency in care. An example of this was for

Ward 24 where patients with respiratory conditions were admitted. The ward had 3 regular agency staff who worked in this area and had specific competencies relevant to this area. For all other areas, staff told us they regularly had shifts which were put out to agency, however these were not always filled. Staff told us that despite there appearing to be no limits on the use of agency staff, there were still a number of shifts which were 'out to agency' which still were not filled.

Medical staffing

The service mostly had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, a recent rise in short-term sickness had been challenging for the service.

The service had enough medical staff to keep patients safe. Medical staff told us they were adequately staffed with no major gaps in any of the medical specialities. However, during an interview with senior staff in division 2, they had raised concerns over medical staffing and the need to continue to recruit at least another 3 substantive positions to cover the demand from the patients. Leaders for division 3 told us they had enough medical staff and this had been as a result of a robust recruitment process.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The medical staff matched the planned number. At the time of our inspection, there were some gaps within the medical staffing due to sickness. However, shifts were usually planned to ensure a balanced skill mix and this would be achieved.

The service had low vacancy rates for medical staff. Despite the senior staff from division 2 informing us of the need to recruit another 3 substantive specialists for their services, information from the trust only showed 1 WTE vacancy.

The service had an average turnover rate of 33.52% for medical staff. There had been 11 medical staff leave in the last 12 months.

Average sickness rates for medical staff were recorded as 3.33% for the last 12 months. The highest rates of sickness were within the junior doctors level for diabetes and endocrinology which recorded an average sickness rate of 6.82% for the last 12 months. There had also been a noticeable increase in sickness for October and November 2022 within the junior doctors working within respiratory medicine. At the time of our inspection, staff told us there were short term staffing pressures due to acute illnesses, this had impacted on the capacity of some staff.

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work. There were locum staff working within the medical specialities to help the service meet the demands. Senior staff from division 2 spoke highly of a locum consultant who had proactively worked with junior doctors for their training and development.

The service always had a consultant on call during evenings and weekends. The service ensured rotas were staffed to provide a high standard of care for all patients regardless of the time or day of the week. Each team were responsible for their patients when admitted to non-medical wards. It was expected that they would be reviewed the same as if they were admitted on a medical ward. Arrangements for handovers and shift changes ensured that patients were protected from avoidable harm.

Records

Medical care (including older people's care)

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

Records were mainly contained within the trust's electronic system which was now in place across all acute locations. All staff required their own unique log in details to be able to work the system and therefore this ensured that records were mainly stored securely. We did observe some occasions when the computers remained logged into the electronic system, however this was not observed on all wards and locations we visited. The system was also observed to 'time out' quite quickly (automatically log off) when this was not used. There were still a small number of paper documents at the end of beds or outside of side rooms, however these were mainly to keep a record of safety checks completed on patients.

Patient notes were mainly comprehensive and all staff could access them easily. We reviewed 32 sets of complete notes on the electronic system and found most entries to be comprehensive with a clear plan in place. The system ensured there were date, time and staff names recorded for each entry. However, we noticed a number of entries which were recorded as edited or unfinished. It was not clear as to what impact this had on the completeness of notes and plans for patients care and treatment. Staff were also not sure whether they were alerted if records were updated.

When patients transferred to a new team, there were no delays in staff accessing their records. All locations where adults were admitted were now using the electronic record system. This therefore meant that there were no delays in staff accessing the patient's records.

Medicines

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

Staff followed systems and processes to prescribe safely, however medicines were not always administered as prescribed. An Electronic Prescribing and Medicine Administration (EPMA) system had recently been implemented which included inbuilt safety features to improve patient safety. We looked at 42 patient medicine records which all documented the reason for prescribing medicines including strength, dose, routes of administration and specific times of administration.

Allergy statuses of patients were routinely recorded on all medicine records seen. The EPMA system would alert and warn the prescriber if they prescribed a medicine that the patient had a documented allergy to. This safety feature helped to reduce and prevent harm.

Venous thromboembolism (VTE) risk assessment outcomes and prescribing were completed on the EPMA system which would alert the prescriber to prescribe treatment if needed.

Weights of patients were recorded on medicine administration records which is important for calculating weight-based medicines prescribing.

The principles of antimicrobial stewardship were implemented which included review dates for re-assessing prescribed antibiotic treatment.

However, medicines were not always administered as prescribed. The reason for missed doses was not always recorded and staff did not always check and follow up on any missed doses to ensure patient safety. For example, on ward 9, the medicine records for one patient showed that they had not had a pain-relieving patch changed on the day it was due

and no reason was documented. Staff spoken to were not aware the medicine had been missed and no action had been taken. A further two patients had not been administered intravenous antibiotics at the time they were due and no reason for the missed doses was documented. Staff spoken with could not explain why the doses had been missed and no action taken. It was acknowledged that nursing staff shortages on the ward had impacted on medicine administration rounds. However, this meant we could not be assured that patients were being administered their medicines as prescribed.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Due to ongoing national difficulties in the recruitment of hospital pharmacists there were vacancies within pharmacy. However, the pharmacy team were working hard to maintain a strong presence on medical wards to ensure prescribed medicines were reviewed and checked to optimise the best use of medicines for patient safety.

Reviews of patients prescribed high risk medicines were prioritised. A seven-day clinical pharmacy service was provided to the acute medical unit. This ensured medicines safety.

Staff completed medicines records accurately and kept them up-to-date. The EPMA system ensured that medicine records were completed. Pharmacists recorded interventions, advice and reviews onto the EPMA system to ensure patients medicines information was up to date, accurate and complete. We saw evidence that pharmacist clinical advice notes were acknowledged by doctors and action taken.

Staff stored and managed all medicines and prescribing documents safely. Medicines were stored in locked clinic rooms with secure access to authorised staff. The AMU had a dedicated separate drawer for all Parkinson's Disease medicines which helped locate these time critical medicines quickly.

Medicine stocks were stored and managed in line with standard operating procedures.

Medicines room and fridge temperatures were within the recommended range, checked and recorded daily. Staff were aware of what appropriate action to take if deviation occurred.

Emergency medicines were available and stored in tamper proof trolleys or boxes. Checks were recorded and undertaken daily to ensure equipment and medicines were within date and safe to use in an emergency. However, we found a tube of glucose in the 'hypostop' kit on Ward 8 which had gone out of date at the end of October 2022. Staff had recently signed to indicate this equipment had been checked.

Controlled drugs (medicines requiring more control because of their potential for abuse) were managed effectively and stored safely and securely. Twice daily checks were undertaken and recorded to ensure safe storage.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. The pharmacy team ensured that all new patient admissions and any newly prescribed medicines were checked on medical wards.

Medicines reconciliation should be completed as soon as possible when patients move from one care setting to another and within 24 hours of admission. It is the process of accurately listing a person's medicines when they are admitted or when their treatment changes. Medicine reconciliation audits showed that between April and June 2022 (quarter 2) 82% were undertaken and completed within 24 hours.

Medical care (including older people's care)

Staff learned from safety alerts and incidents to improve practice. There was a system in place for reporting incidents and for receiving and dealing with medicines safety alerts. We were told there was an 'Incident of the Month' which would be shared across all staff via email.

The service ensured patients behaviour was not controlled by excessive and inappropriate use of medicines. Prior to our inspection, we were aware of an incident where a patient received more than the recommended dose of a medicine commonly used in chemical restraint in 24 hours as part of the care and treatment plan to manage their behaviour. During this inspection, we reviewed medication records and case tracked patients with complex needs to ensure there were no concerns over the inappropriate use of medicines to control a patient's behaviour. We found patients who were prescribed medicines to manage their behaviour, however none of them had been given excessive amounts or more than the recommended amount in 24 hours.

As part of the Learning Disability and Autism Spectrum Implementation Plan, work was in progress to ensure the trust had fully embedded NHS England's STOMP programme (stopping over medication programme). The programme was specifically focused on reducing the overuse of medicines known as psychotropic medicines which were administered to manage behaviour in patients with a learning disability, autism or both.

Incidents

The service mostly managed patient safety incidents well. Staff recognised and reported most incidents and near misses. Managers investigated incidents and when things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored. However, not all staff received feedback and were unable to give examples of any lessons learned.

All staff knew what incidents to report and how to report them. Staff mostly raised concerns and reported most incidents and near misses in line with trust policy. All staff we spoke with, spoke confidently around the incident reporting policy and what incidents should be reported. However, there was some concerns raised around not always having the time to submit all incident report forms. On one ward, staff told us of incidents which had happened during that shift. They knew they would have difficulties submitting any incident reports that day due to the demand on them. They told us, if incidents occurred, they often completed incident reports in their own time. Staff were confident they reported all significant incidents where patients were harmed, however some other incidents (staffing shortages for example) were not always reported.

The service reported no never events on any wards in the last 12 months. We were not assured shared learning about never events and serious incidents occurred within the service. Staff within some wards were unable to recall details of any significant incidents when asked during the inspection, whether these had occurred on the ward or outside of the ward. Within some areas, staff were unable to recall their last serious incident.

Staff reported serious incidents clearly and in line with trust policy. There were 314 serious incidents reported between October 2021 and October 2022 under the trust medical speciality (not location specific). Of these 63% were related to Healthcare Acquired Infections and infection control incidents.

Medical care (including older people's care)

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Senior staff were able to describe the process for undertaking, and when to formally undertake the duty of candour. We reviewed a selection of serious incidents and identified duty of candour had been appropriately undertaken in each of them. Staff were also aware of the requirement to be open and transparent when things went wrong and would offer an apology to patients.

Staff did not always receive feedback from investigation of incidents, both internal and external to the service. Staff told us they rarely received any feedback about incidents they raised. This contributed to the problems of improving the learning they identified within any incident. Staff on 1 ward told us of issues in relation to staff safety. Staff had mostly reported these incidents using the incident reporting system, however none of the staff we spoke to who raised them had received any feedback in relation to this.

Staff told us they rarely had meetings where feedback from incidents and improvements to patient care would be discussed. However, staff told us they communicated through other methods which gave them the opportunity to discuss any incidents should they need to.

Despite staff not being able to discuss examples of change, information provided after the inspection demonstrated that changes had been made as a result of learning from incidents.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We reviewed a selection of root cause analysis investigation reports in relation to this core service at Good Hope Hospital. The investigations appeared thorough, with learning identified and an action plan produced to support improvements. However, we were not assured these incident investigations and the learning from them were always discussed with other members of staff. When significant incidents had occurred, not all staff told us their managers debriefed and supported them after the serious incident.

Information received after the inspection showed the service reviewed patient safety notices and implemented any improvements and changes relevant to the care and treatment, they provided patients.

Is the service effective?

Requires Improvement ↓

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

Evidence-based care and treatment

The service provided care and treatment mostly based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Medical care (including older people's care)

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance where available. Staff endeavoured to deliver high quality care and treatment in line with, in date policies, procedures and guidelines which were based on best practice and national guidance and policies where available. Staff assessed patients' needs and planned and delivered care in line with National Institute for Health and Care Excellence (NICE) and the relevant royal societies.

The trust regularly monitored the compliance against relevant NICE guidance at the divisional quality and safety groups and also the clinical quality monitoring group. This was then regularly presented to the trust board during quarterly board meetings. At the most recent board meeting in October 2022, papers indicated that the trust were 57% compliant with NICE guidelines.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Details of patients sectioned under the Mental Health Act were also identified during safety huddles, enabling staff to identify if any further measures were required to keep patients safe. In addition to patients who were under a section, patients who were being deprived of their liberties were also identified and any additional measures or follow up discussed during the safety huddle.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health and supported them to meet their needs. The service made adjustments for patients' religious, cultural and other needs. However, patients who required additional support were not always identified in a timely manner and special feeding techniques were sometimes delayed.

Staff made sure patients had enough to eat and drink. We observed staff ensuring they asked patients what they would like for their meals and assisting patients who required help to ensure they were adequately nourished. This was then immediately updated on food charts. Meals were available to patients to meet all religious and cultural needs and met the needs of those with allergies and intolerances.

Staff mostly completed patients' fluid and nutrition charts fully and accurately. We did however, observe some patients who were on fluid charts not having all of their inputs and outputs documented. This meant it was difficult to assess whether the patient was in a positive or negative fluid balance which could impact their medical condition.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. However, we were not assured all staff completed these accurately and that not all patients were referred to the dietitian when risk was identified. Within one of the records we reviewed, staff had not identified the patient was at risk of malnutrition. However, the patient was identified by the dietetic team as someone who may require additional nutritional support from doing a review of the electronic system. When a recalculation of the malnutrition risk assessment was completed, the patient scored 3. The risk assessment used by the trust identified anyone scoring 2 or more as a high risk of malnutrition.

We identified a number of patients who were classified as nil by mouth (NBM). It was clear from the notes why some patients were NBM, however, not in all cases. It was also not clear as to what action staff had taken and no updated malnutrition risk assessment completed despite a change in circumstances. Specialist staff were aware there were patients who unfortunately required additional support, however due to in accurate assessments resulting in no referral to the dietetic team, it was not always possible to identify who these patients were. Specialist staff were observant when

completing reviews in ward areas for patients who may require their support and would speak with the nursing and medical staff to enquire if any support was required. There was a standard operating procedure (SOP) in place to support staff when manging patients who were NBM, however we were not assured staff were always referring to this when caring for patients.

Following the inspection, we held an interview with senior specialist staff who provided support to staff at this location. It was acknowledged that there were some issues with staff completing accurate malnutrition risk assessments and this had led to a piece of working being completed to target training to staff who required this. The clinical dashboard also contained real time information on the performance of malnutrition risk assessments within the ward areas to help with the focused work of the team. Dietetic staff also stated there was training within the electronic learning system which staff could complete, however, this was not mandatory. Despite these actions in place to mitigate the risk, patients were still not having accurate assessments completed which resulted in them not having their needs met.

In addition to the challenges around staff completing accurate malnutrition risk assessments, the referral rates for patients who required support had temporarily dropped when the electronic system was put in place. This part of the challenges the dietetic team faced had now resolved.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. However, staff from the teams told us the specialist teams had significant vacancies which the trust were addressing. For the patients who we identified as a risk of malnutrition, we observed documented evidence in their notes of reviews from specialist staff.

Incidents reviewed prior to the inspection had identified in some cases where patients had experienced delays in receiving nutritional via parental and enteral feeding routes. During our inspection, we reviewed notes for patients who required additional nutritional support and who were waiting for an alternative method of delivering nutrition. We raised this with the specialist staff during the interview who acknowledged there could be some delays for patients who required this due to lengthy waiting lists for endoscopy (for patients who required the percutaneous endoscopic gastrostomy feeding tubes) as well as some delays with staff who complete procedures to insert PICC lines (peripherally inserted central catheter) for patients who required parental nutrition. There were plans in place for managing this situation.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff assessed patients for pain during routine observation times using a numerical scoring tool. Staff had access to alternative pain assessment tools for patients who were unable to verbally communicate.

Staff prescribed, administered and recorded pain relief accurately to patients who required this. Where patients reported experiencing pain, they received pain relief soon after requesting it. Staff regularly asked patients during medication rounds whether they required any additional pain relief and immediately administered this if required.

Patient outcomes

Medical care (including older people's care)

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service usually participated in relevant national clinical audits. However, due to the pandemic, a number of the national audits were suspended and/or postponed enabling staff to concentrate on the operational delivery of patient care. The majority of data available in relation to national audits was therefore reported on in the previous inspection report, published in October 2021.

The service had continued to submit data for the Sentinel Stroke National Audit Programme on a quarterly basis. Results from April to June 2022 showed the service at Good Hope Hospital were graded D (this was using a scale of A to E where A is considered the best). This had remained stable for the previous 2 quarters, although there were some indicators which had fluctuated in performance during this time. The indicators for specialist assessments. Speech and language therapy and multidisciplinary team working had all remained on a grade of E. However, there were noticeable improvements in physiotherapy, occupational therapy and standards by discharge.

Outcomes for patients were reviewed at divisional and trust wide safety and quality meetings. Details from these meetings were also part of the regular agenda for trust board meetings where outcomes were discussed.

Managers and staff used the results to improve patients' outcomes. Managers and staff carried out a programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits. Staff provided evidence of local audits which were conducted by staff and which had been key to improving the care and treatment patients received.

Improvement is checked and monitored. The service at Good Hope Hospital were now using the clinical dashboard. This enabled managers to have real time awareness of performance and how improvements were impacting on the outcomes for patients. There were 17 clinical indicators within the dashboard, these included (but not limited to) missed doses of antimicrobials, observations performed and malnutritional risk assessments conducted within 6 hours of admission.

The endoscopy unit had JAG (Joint Advisory Group on gastrointestinal endoscopy) accreditation at the time of our inspection. However, staff told us this was currently being reviewed.

Competent staff

The service generally made sure staff were competent for their roles. However, appraisal rates were impacted by current pressures and demands on the service and staff did not always receive supervision meetings to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work. Where applicable, managers made sure staff received any specialist training for their role. Staff told us about competency packages that had been put in place for supporting staff to care for patients receiving non-invasive ventilation. This had also been extended to other ward staff who may be required to support the respiratory ward at times of low staffing. There was also a comprehensive competency package in place for staff joining the endoscopy unit.

There was inconsistent feedback in relation to managers identifying training needs for their staff and them having the time and opportunity to develop their skills and knowledge. Staff told us they had the opportunity to discuss training needs with their line manager during their appraisals, however current pressures meant they were not always able to attend courses or training sessions to develop their skills and knowledge. Some staff also raised concerns over not having regular appraisals with their managers. Information received after this inspection showed 65% of non-medical staff (including nurses and healthcare assistants) had received an appraisal at the end of November 2022. The information showed there were some wards which had a higher compliance than others. The highest compliance rate was 95% compared to the lowest of 51%.

The information received after the inspection also recorded 40% of medical staff had received an appraisal at the end of November 2022.

We were not assured that managers always supported nursing staff to develop through regular, constructive clinical supervision of their work. However, medical staff spoke highly about the support they had and the opportunities to develop through regular, constructive clinical supervision of their work

The clinical educators tried to support the learning and development needs of staff. However, staff told us due to pressures experienced around staffing, there was an expectation for them to also work clinically. Clinical education staff tried to ensure when working clinically this also involved their role in helping others to develop, however this was not always possible. Staff tried to support those working within wards and departments with additional training and education, however due to the current pressures, staff were not always able to attend these sessions.

Most staff told us staff meetings were rarely held now due to the demands on the service. Any important matters would be communicated at safety huddles, handover or via emails.

Managers identified poor staff performance promptly and supported staff to improve. Managers would engage with the human resources (HR) department for further advice and support for managing staff performance if required.

Multidisciplinary working

Doctors, nurses and other healthcare professionals mainly worked together as a team to benefit patients and supported each other to provide good care. However, some concerns were raised over the joined up working with mental health teams.

The multidisciplinary team consisted of doctors, nurses, healthcare assistants, physiotherapists, pharmacists, microbiologists, dietitians and specialist nurses (including pain, learning disability, tissue viability). All members of the team worked well together to ensure the best outcome for the patient. All staff spoke positively about the support they received from the wider multidisciplinary team (MDT).

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Patients had their care pathway reviewed by relevant consultants. These meetings were usually well attended and included other external members of the wider MDT if required. The wards had discharge coordinators who were observed to be a catalyst for improved MDT working, especially when patients were discussed in terms of their discharge plans.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression and worked across health care disciplines and with other agencies when required to care for patients. However, we were not assured this was always an effective collaboration between the teams. During our inspection, staff told us of concerns

over the 'disjointed' working between teams who provided physical care for patients and the teams for providing mental health support. Examples were discussed where communication had not been effective and care plans not shared with the team providing mental health support. In one example this had resulted in a patient who required ongoing inpatient support missing out on the placement the mental health team had secured due to ineffective working and communication. Staff indicated this was not a one off with regular delays in management of patients who had both physical and mental health needs. Staff, however, were complimentary about the timely response they had when escalating patients to the mental health team.

Seven-day services

Key services were available seven days a week to support patient care. However, services were not always provided in a timely manner.

Consultants led daily ward rounds on all medical wards, including weekends. Patients were reviewed by consultants depending on the care pathway. However, staff raised concerns with us over patients who were admitted on to non-medical wards. At times, staff told us they struggled to get the patients doctors to attend the wards, regardless of whether this was during the weekdays or weekends. During our inspection, staff told us about a patient who they were trying to escalate to the medical team in charge of their care, however this was proving difficult.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, 7 days a week. The endoscopy unit also provided an on-call service for patients admitted as an emergency for gastrointestinal bleeds.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards. Information was available to patients and their relatives which was aimed at promoting healthy lifestyles, as well as educating patients on certain health issues.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff were also able to signpost patients and their relatives to other services for further information and support if required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. All staff were aware of gaining consent from patients prior to completing any treatment or procedure. This

also involved implied consent from patients when undertaking activities such as monitoring a patient's blood pressure. Where more formal consent was required to undertake clinical procedures, this was completed in accordance with policy and legislation. When patients were assessed as lacking capacity to consent for their procedures, staff knew what process to follow to ensure consent was obtained in relation to the patients best interest.

Staff made sure patients consented to treatment based on all the information available and clearly recorded consent in the patients' records. Staff ensured patients were provided enough information to make informed decisions and give informed consent. Patients we spoke with all told us they received enough information to give their consent for procedures.

Staff generally understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff spoke confidently about identifying patients who they had concerns over their capacity to make decisions over their care and treatment and actions they needed to take to assess this. However, the majority of capacity assessments were completed by medical staff despite nursing staff identifying the concerns. We did observe one record for a patient who required a capacity assessment to be completed, however we were unable to locate this at the time. Staff recorded formal capacity assessments on the trusts electronic records system.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Information received after the inspection showed 91% of staff working in this service were in date for safeguarding: mental capacity training. This was just above the trust's own compliance target of 90%.

Staff generally understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Some staff believed there was some confusion and lack of understanding in relation to the Mental Health Act, however they knew who to contact for support with patients who were admitted under this Act.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. Ongoing management of the deprivation of liberty safeguards applications was delegated to ward staff. The safeguarding team documented in all patient notes who had a Deprivation of Liberty Safeguards order applied for, reminding staff to contact the local authority after 2 weeks. Between 1 June and 30 November 2022, the trust informed the CQC of 609 applications made to implement the Deprivation of Liberty Safeguards. Of these, 28 were in relation to patients at Good Hope Hospital. These notifications also included updates of where applications had been withdrawn due to the patient being discharged from the service.

Managers and staff from the specialist team monitored how well the service followed the Mental Capacity Act. We requested information after our inspection in relation to the monitoring of performance in relation to mental capacity assessments. There were no specific audit reports in relation to the completion of capacity assessments, however we were provided with details of audits which included this information. There was an audit in relation to Do Not Attempt Cardiopulmonary Resuscitation decisions and ReSPECT (recommended summary plan for emergency care and treatment) form completions which touched upon the inclusion of capacity assessments. There was also an audit completed in relation to patients with a learning disability (LD) to ensure the LD standards had been implemented. Part of this reviewed the completion of a capacity assessment. The most recent results for November 2022 showed compliance had reduced to 89% from 96% in September 2022.

Medical care (including older people's care)

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 dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. All staff we spoke with told us how they felt they were not always able to provide patients with the compassionate care they wanted to deliver due to the overwhelming demand on them due to a lack of staffing. However, we observed care being provided to patients in a dignified manner. When receiving personal care, staff ensured curtains were closed to protect their privacy and dignity. All patients we spoke with were complimentary about the staff who were delivering care and treatment.

Patients said staff treated them well and with kindness. No concerns were raised by patients or their relatives in relation to how they were cared for. All spoke of how kind staff were despite them being extremely busy. We observed relatives thanking staff for the care they had provided their family member and the kindness they had shown them.

Staff did not always follow policy to keep patient care and treatment confidential. During our inspection, we observed a handover occurring outside a patient room due to the challenges around staffing and the high acuity of the patients admitted. This meant despite staff trying to keep the volume of their conversations low, patients nearby were able to hear aspects of the handover. We observed a patient who overheard information which they believed to be about them which then upset them. However, the information they overheard was not in relation to them.

Staff mostly understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We observed examples of respectful and non-judgemental care and treatment for patients who were admitted with additional needs other than their physical health needs. Staff were complimented on their patience and compassion for how they cared for all patients. However, we did observe a staff member being disrespectful about a patient with behavioural needs who was becoming challenging for staff during a short-staffed shift.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff were able to discuss examples of care when they had respected the specific needs of a patient. Cultural and religious needs were well understood, and staff ensured any specific cultural needs would be considered whilst admitted. Staff also told us the trust had good access to various religious leaders to support patients of all faiths. During our inspection, we observed patients receiving a visit from a faith leader who was providing them with support and compassionate care.

Emotional support

Medical care (including older people's care)

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. 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. In addition to ward staff providing emotional support to patients and their families, we also observed compassionate care volunteers who provided support mainly to patients who were receiving end of life care. However, staff believed they also supported patients and families who required additional support during difficult and distressing admissions.

Most staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. However, staff acknowledged that staffing shortages could sometimes hinder their immediate response to provide support to distressed patients.

Staff told us breaking bad news was part of their wider communication training. Staff demonstrated empathy when having difficult conversations. Patients told us staff were supportive and empathetic when having difficult conversations with them.

Additional support to patients was also provided by specialist nurses and faith leaders. We observed a range of specialist nurses and faith leaders attending to patients during our inspection and they all provided patients with the emotional support and care they required.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Prior to the inspection, we received concerns from members of the public that patients or their relatives were not communicated with and were not aware of the plans in place for their care and treatment. Concerns also included staff were regularly too busy to communicate with them, stating they would return or call them back, but never would. However, we observed staff engaging with patients and their families, updating them on details of the planned care and treatment. Patients also told us they were aware of their treatment plans and were regularly updated by the staff.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Patients told us they believed staff tailored conversations to their needs. On ward 8 we observed a communication box that aided staff to hold conversations with patients who required additional support with communication.

Staff supported patients to make informed and advanced decisions about their care. Patients were given all essential information to enable them to make informed decisions and where necessary give informed consent. Where appropriate, staff took the time to discuss with patients whether they had any advanced decisions in relation to their care and treatment.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff provided information about the friends and family test (FFT) to patients to encourage them to provide their feedback.

Medical care (including older people's care)

Patients gave positive feedback about the service. The main source of feedback was through the FFT. Information received after the inspection showed there was a varied response to the wards and the care and treatment provided in this service. The information showed between 71 and 100% of the patients who received care and treatment at this service between September and November 2022 would recommend the service to their friends and family.

Within some of the wards, we also observed boards displaying 'you said, we did' examples. Staff were keen for patients to provide feedback directly to them in relation to their experience on the ward. This enabled the managers to take on board the feedback and where possible, make immediate changes and improvements.

Is the service responsive?

Requires Improvement  

Our rating of responsive stayed the same. We rated it as requires improvement.

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 service had systems to help care for patients in need of additional support or specialist intervention. Since the previous inspection in June 2021, additional capacity had been opened recently in the form of modular buildings, which had been designated to caring for patients who had strokes. This enabled the service to start reconfiguring the wards to enable more of a speciality approach. In addition to this, a new respiratory support unit had been opened to enable staff to deliver care to patients with specific respiratory needs. This enabled patients to receive the specific support required by staff who had undergone specific training and competency assessments to deliver the care and treatment.

The service continued to try and improve the experience older patients had when coming to the hospital. The avoidable admission work continued by involving the multidisciplinary team to ensure older patients had the support they required at home. This continued to rely and support from other organisations across the care system in the Birmingham and Solihull region.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Staff were aware of the standards around single sex accommodation. There had been no breaches of this within the service reported between May and November 2022.

Not all facilities and premises were appropriate for the services being delivered. Despite the day rooms still being used for alternative purposes, the service was still challenged from a demand perspective. This had seen additional modular wards being built to increase the capacity for the service. However, it was still evident that there was a challenge from a capacity perspective with patients being made to sit in chairs or wait in the corridors on trolley's whilst they waited for beds to become available.

Medical care (including older people's care)

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, a learning disability or dementia. The trust also had a vulnerabilities team who regularly reviewed patients with complex needs. The team were available on site between Monday and Friday.

Managers monitored and took action to minimise missed patient appointments. Managers ensured that patients who did not attend appointments were contacted. Staff told us missed appointments were reducing within the endoscopy department. Additional lists had been added on Saturday's due to the number of patients waiting for their appointments.

The service relieved pressure on other departments when they could treat patients in a day. The endoscopy unit ensured that patients who required follow up with specialist teams following their investigations were organised the same day to prevent delays in follow up. The division leads were also developing further same day services within the acute medical services which were aimed at improving the patient experience for elderly patients.

Meeting people's individual needs

Staff took account of patients' individual needs and preferences and tried to make reasonable adjustments to help patients access services. However, the demands on them meant they were not always able to meet patient's individual needs.

Staff tried to ensure patients living with mental health problems, learning disabilities or dementia, received the necessary care to meet all their needs. Staff in all ward areas were aware of the needs of patients with complex medical and psychological histories and escalated these patients when additional support was required. However, staff told us due to the pressures and demands, they did not always manage to ensure their needs were met. The vulnerabilities team were especially key to providing support for caring for patients who had additional needs however, they were not able to always be with patients for long periods of time. This meant if no additional staff members were allocated to the ward, some patients who required additional support did not always receive this. During our inspection, we observed within some of the wards where registered mental nurses were allocated to provide 1 to 1 care and support for a patient who required this level of support to meet their needs. Staff told us this did not always happen despite placing regular requests in for patients.

Where patients were admitted from other care organisations where they received additional support, staff encouraged the carers who accompanied them to remain with them. Managers would often liaise with the other care organisations to identify if a member of staff who the patient was familiar with would be able to remain with them. Staff saw this a very positive approach as most of the challenges they faced were as a result of patients feeling confused and vulnerable and therefore a familiar face was usually seen as a positive and had a calming influence on the patient.

Staff on some wards told us there were equipment boxes available which they could use to occupy patients with complex needs. These included puzzles, fidget toys and colouring activities. Staff told us prior to COVID-19, there were volunteers who would come to the wards and complete some activities with patients. This was always well received by patients, especially those where distraction therapy was required to keep them safe. Staff told us they wanted to be able to spend more time with patients and complete activities with them as this was proven to reduce incidents of falls and aggression, but due to the demands on them, this was not possible.

The trust were working on splitting the dementia and delirium strategy so they could focus on just the dementia strategy for the current time. Work began on this in November 2021. Information received after the inspection showed this was still work in progress and no date was confirmed for when this would be released.

Medical care (including older people's care)

Wards we visited were still not designed to meet the needs of patients living with dementia and day rooms were still not available for patients to use We identified concerns over the décor of the wards during our previous inspection and the impact this had on patients living with dementia. Staff on Ward 8 told us they were looking into modernising the bays to meet the needs of patients living with dementia, but there was no time frame in place at the time.

Staff did not always support patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. We observed where patients were admitted and required a patient passport to be completed, however this was not completed or partially completed. Records showed the patients had been reviewed by the vulnerabilities team who had requested this to be completed previously but this remained incomplete. The use of 'this is me' documents was part of the dementia strategy. Despite our findings during inspection, a trust wide audit dated November 2022 showed trust were 95% compliant with this standard. However. of those who did not have a document completed, it was reported that there had been numerous requests by the vulnerabilities team, which supports what we sound during inspection.

Staff told us they understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The trust as a whole were working on raising the awareness of the Accessible Information Standards, however local knowledge of this within the areas we visited still remained variable. Part of the Learning Disability and Autism Spectrum Disorder implementation plan identified there was still ongoing work required around easy read appointment letters and flexible appointments system.

Staff had access to communication aids to help patients become partners in their care and treatment. We observed communication aids were readily available on ward 8 for staff to use. All staff told us they had access to communication aids and could approach the vulnerabilities team for additional resources if required. The trust had also started to provide all staff with basic level 1 Makaton to enable them to sign basic care needs. Makaton is a unique language programme that uses symbols, signs and speech to enable people to communicate.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service had information leaflets available in languages spoken by the patients and local community. Staff told us there were no difficulties arranging interpreters for patients whose first language was not English. Most information leaflets we observed during the inspection were in English, however, staff were able to access leaflets in alternative languages if required.

Patients were given a choice of food and drink to meet their cultural and religious preferences. The service had a wide range of options available to meet all cultural and religious preferences.

Access and flow

There was a high demand on the service which meant there were sometimes delays in people receiving the right care promptly. The service was still working on their recovery plan post COVID-19 pandemic which meant waiting times from referral to treatment and arrangements to admit, treat and discharge were still impacted.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Performance was monitored and reported at divisional quality meetings. Information received after the inspection showed division 3 had a referral to treatment (RTT) performance recorded at 82% in October 2022, which had been recorded as a stable figure. No target was identified within the divisional board meeting minutes. There were no long waits recorded anymore of 104 weeks. It was however noted that there were still some challenges in stroke services.

Medical care (including older people's care)

Reports from Division 4 which endoscopy came under, showed their performance was improving with their 2-week referrals now being close to the internal targets of 93% for October 2022.

Managers worked to keep the number of cancelled appointments to a minimum. When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. Staff within endoscopy were keen to ensure all patients received their appointments in a timely manner and had even put in additional lists to enable them to keep to this.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. The trust used the Bristol Push Model which aimed at increasing capacity within the emergency department by sending patients to other wards and departments. The service regularly received patients throughout the day when there were expected discharges. Staff told us they had concerns over this process due to the extra demand placed upon them. Patients would regularly be made to wait for the bed in corridors or sat on chairs near nursing stations. Staff highlighted safety concerns over patients who were deemed appropriate to be moved under this process, however, were later identified to be significantly unwell. Staff had escalated their concerns about this process however due to the demands on the service, the process continued to be used. During our inspection, we observed a patient who had been moved on to a ward under this process despite there being no expected discharges that day. Staff told us this was a regular occurrence and was difficult to then transfer a patient to another ward.

Managers and staff worked to make sure patients did not stay longer than they needed to. Staff told us the length of stay on most wards had increased due to the delays in discharging patients. Data showed that for elective admissions, patients admitted under general medicine had a much higher length of stay of 16 days compared to the England average of 7.2 days. Patients admitting under the older person's pathway on a non-elective admission had a higher length of stay of 12.8 days compared to a national average of 8.8 days.

The service moved patients only when there was a clear medical reason or in their best interest. Staff tried not to move patients between wards at night. However, due to the significant challenges at the trust as a whole, staff told us they regularly had patients transferred to and from their wards during the night. Staff raised concerns when this involved patients with cognitive impairments, however due to the need for patients to move when a bed became available, this was deemed a necessity. Information received after the inspection stated bed moves were monitored during bed meetings. Staff tried to ensure only essential moves occurred, however due to the demands on the service, it was recognised that some patient moves occurred to enable more acutely unwell patients to be admitted.

Staff supported patients when they were referred or transferred between services. Managers monitored patient transfers and followed national standards. Managers were aware of patient moves between wards/services and tried to ensure they were kept to a minimum. Staff tried to ensure patients were only moved between wards for speciality reasons. When patients were transferred, staff ensured detailed SBART (situation, background, assessment, recommendation and transfer) documents were completed for each patient as well as providing a verbal handover of the patient.

Staff started planning each patient's discharge as early as possible. During the previous inspection, we reported on the introduction of flow coordinators, which had taken over the role of bed managers. This role had continued to thrive and was an integral part in of the discharge process. Further investment was being made in this role due to the success seen already.

Medical care (including older people's care)

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Staff ensured the mental health team were involved with patients who were identified as requiring additional mental health support on discharge from hospital at an early stage. Examples were provided however where discharge arrangements had been impacted due to poor communication between the physical and mental health teams caring for patients. As a result of this, these patients were then delayed discharging.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the highest number and took action to try and prevent them. Flow coordinators had been identified as key to trying to reduce the impact of delayed discharges, by engaging earlier with external organisations to try and ensure patient discharges went ahead in a timely manner. However, staff told us there were challenges in relation to delayed discharges. Availability of rehabilitation services and delayed care home placements were identified as the top reasons for delayed discharges by staff.

We were not assured managers worked to minimise the number of medical patients on non-medical wards. Due to the demands on the service, medical patients were regularly admitted to non-medical wards (outliers). On the second day of our inspection, there were 35 medical patients admitted on non-medical wards, with Ward 7 (a surgical ward) recording the most patients.

There were arrangements in place for medical staff to review any medical patients on non-medical wards. However, staff told us they regularly struggled to get medical staff to review medical 'outlier' patients. On the second day of our inspection, staff from ward 16 had tried to contact doctors 6 times to review the medical patients. They had escalated this to the site managers due to the concerns they had for these patients.

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 and investigated them.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Patients told us they felt comfortable raising any issues with the staff caring for them at the time.

Staff understood the policy on complaints and knew how to handle them. Staff tried to resolve any complaints or concerns locally; however, they were aware of the escalation policy if this was required.

Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. There were 73 complaints raised for medical services at this location between June and November 2022. The main theme of the complaints received were in relation to patient care, which included nutrition and hydration.

Staff told us not all managers shared feedback from complaints with them. Not all staff had complaints and concerns outcomes shared with them. This meant there were not all aware of any learning which had been implemented as a result of complaints. Some staff told us the most significant of complaints would be shared during handovers and safety huddles, however this was not frequent.

Medical care (including older people's care)

Not all staff were able to give examples of how they used patient feedback to improve daily practice. Within some wards, they displayed information in relation to feedback they had received and the actions they had taken to improve. However, not all staff were able to share examples of where feedback from concerns and complaints had been used to improve daily practice.

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 and mainly understood the priorities and issues the service faced. However, we were not assured leaders had appropriately managed the priorities, issues and mitigated the risk adequately. There were also mixed responses from staff about leader's visibility and approachability in the service for patients and staff.

Leadership for medical services mainly came under Division 2 and Division 3 although there were some areas of the speciality which also came under Division 4 and 7. Leadership of the divisions was fairly similar in most divisional structures. Leadership was provided by the divisional medical director, divisional director of nursing, divisional director of operations and the managing director. Divisional leads were supported by deputies and matrons. Divisional leads were knowledgeable about their main challenges which was largely around staffing, they were focused on the importance of delivering safe care and treatment. However, we were not assured they had acted sufficiently to mitigate the risk.

Junior doctors told us they felt well support by their registrars and consultants and spoke of how approachable they were.

There was a mixed response from front line staff about the leadership across the organisation including, from their line managers and matrons of the service. Most nursing staff were complimentary about their ward leaders and felt they were highly visible and supportive, however not all staff on the wards were as complimentary about the leadership provided by the matrons and above. In some areas where there were large vacancies and high demand, even when matrons have been on site, staff had commented on how they would not attend the ward to support the nursing team.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and staff understood and knew how to apply them and monitor progress.

Staff were generally aware of the trust's strategic aims to always put the needs and care of patients first and to "build healthier lives". Each division had a local strategy and vision to improve services. Most staff were aware of the trust's overall strategy and vision and how this was reflecting in their own local areas. Progress against the strategy was monitored at the divisional governance meetings which occurred.

Medical care (including older people's care)

Culture

Staff did not feel respected, supported and valued and this was impacting on the morale within the service. However, all staff without exception were focused on the needs of patients receiving care. The service had an open culture where patients and their families could raise concerns without fear. The service promoted equality and diversity and provided opportunities for career development.

Since the last inspection in June 2021, there had been a deterioration in the culture of the staff working within the medicine core service at this location. All staff without exception told us their morale was low and this was largely down to the reduced staffing numbers and higher acuity of patients they were managing. Staff told us even when concerns were raised, nothing appeared to be done and they were "left to get on with it". Staff from other departments who use to work on the medical wards sought the inspection team out whilst we were on site to discuss their concerns and how they had to leave the wards they use to work on due to the pressures placed upon them and the "unsafe situations" they were faced with on a daily basis. Staff regularly told us they were also concerned about the consequences on their professional registrations due to the unsafe situations they were faced with. We received whistleblowing enquiries from staff whilst we were on site informing us about the concerns they had about staffing which was impacting their morale and the culture within the areas they worked.

Staff told us due to the acuity of the patients they were caring for, they regularly ended up with physical injuries as a result of the constant manual handling they were performing and from assaults which they regularly experienced. This was also impacting morale for staff on the wards due to short term sickness ending up impacting staffing further.

Staff were aware of the Freedom to Speak Up Guardian (FTSUG) service within the trust, however none of the staff we spoke with had considered approaching them as they were not confident this would result in change.

Staff within some areas had indicated concerns over negative behaviours which they believed to be bullying, had occurred and this had been reported to the managers of the wards. Despite escalating this to their managers, this reported negative behaviour continued to occur in pockets within the service. There were no reports of any discrimination of staff for any reasons within the medical core service. Staff were provided with opportunities to progress if this was something, they were interested in.

Locally, most staff spoke positively about the ward and department managers, stating they believed they could approach them with any concerns although if required to escalate higher were not always hopeful action would be taken. In one area, staff told us the ward manager was relatively new and worried that when trying to escalate concerns on behalf of the ward staff, they themselves were not supported or listened to. However, not all staff believed the management above this were as positive or approachable. Some staff told us they rarely saw the matron who was responsible for their areas, however staff from a different area were very positive about the support and visibility of their matron.

Leaders of the service believed the well-being of the staff remained a priority for them. We observed staff who had the designated role of providing well-being support to staff visiting wards during our inspection.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff were clear about their roles and accountabilities. However, there were inconsistent accounts about staff meeting to discuss and learn from the performance of the service.

There were governance processes in place in all divisions with the production of detailed information about each division's performance. Information and issues discussed appeared standardised to ensure a consistent approach to governance. Each division held a monthly board meeting which had information from speciality meetings and the quality and safety meeting feeding into them. This was discussed at regular governance meetings and used to demonstrate effectiveness and progress across the service.

We reviewed the minutes of governance meetings and saw a standardised approach to the meetings which covered all pertinent governance points. We saw clear actions identified within the minutes and areas which required escalation.

We observed additional staff members invited to relevant governance meetings to discuss important issues impacting the division. One example we saw was the transition consultant nurse presenting to division 2 due to the large numbers of patients who were transitioning over from paediatric services. We observed the minutes to also contain details of an effective governance process with partner organisations.

Some staff told us ward/department meetings where they were updated on essential information from these divisional meetings were sporadic, with some staff being unable to remember the last meeting held. Most wards held safety huddles in the morning where key ward related topics could be discussed, however these had a very structured approach which focused on the immediate safety aspects on the ward. Some staff told us they had essential updates emailed to them sometimes, however, they were usually too busy to review their emails due to the demands on them during their shifts.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and mainly identified actions to reduce their impact. However, the risks in relation to staffing were not adequately mitigated. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Each speciality had a separate risk register which covered all locations. We saw risks were reported alongside the site to which they applied. Whilst most risks were trust wide, we saw some specific to areas we visited within Good Hope Hospital. Ward 23 (cardiology) had a specific risk around their inability to provide a central cardiac monitoring system due to the vacancies among their staffing. Speciality risk registers were regularly reviewed during divisional board meetings and any new risks escalated.

Without exception, all staff from all roles and responsibilities provided staffing as their main risk within the service. Within some ward areas, it was evident that staffing levels was impacting the ability for staff to provide safe care and treatment, with 2 new falls being reported during our first day of inspection on ward 9 due to the inability to provide 1 to 1 support for patients who were identified as a falls risk. Staff told us this was not a new risk. We reviewed the risk registers which were provided after the inspection. Although staffing had been identified as the main risk across the service, the risk registers provided did not necessarily support this. It was acknowledged that only extracts of the risk registers relevant to the location inspected were provided. However, it would be expected that if the main risk identified by all staff was their staffing levels, this would be evident on all risk registers and details of mitigation provided. Risk registers for care of the elderly and stroke services did not contain details of staffing risks and the risk registers for respiratory and cardiology had staffing within the concerns for why other risks were entered on to the register.

All 'red risks' (those risks which were considered high risks and rage rated as red) were discussed during the quality and safety meetings within the divisions. Copies of minutes identified where staffing had been discussed, however there was

no specific details to identify what aspects of the risk had been discussed. For example, during our inspection we found qualified nurse staffing levels to be significantly low in some areas. From our review of the minutes of the quality and safety meetings, we were unable to identify whether the divisional leads were aware of this. We were therefore, not assured that divisional leads had complete oversight over the staffing concerns within their areas.

As staffing was a known risk across the trust, and also at this location, focused recruitment campaigns had been completed for Good Hope Hospital to try and improve matters. We also spoke with the trust's divisional director for nursing workforce who provided additional information about other recruitment campaigns to improve the staffing situation at the trust. However, a lot of these actions would not be an instantaneous fix and required time before any improvements would be seen.

The service used a clinical dashboard to monitor real time performance and use this data for instant improvements. The dashboard had 17 metrics which managers reviewed, this included completion of observations, completion of malnutrition and other risk assessments, missed antimicrobials and checks of patient wrist bands prior to medication administration. All metrics had a compliance rate which they were measured against and where standards fell, managers would highlight this to the relevant area, and this would be cascaded at safety huddles. Data from the clinical dashboards was also included in the integrated quality reports which were presented at trust board meetings.

Staff were aware of trust plans to manage unexpected events, such as fires and power outage. Staff were unable to recall the last time they completed any practical training for the management of a fire.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service collected reliable data and analysed it. Staff told us they had administrative support to help collect reliable data for national audits to ensure accurate collection and submission of the data. The service also ensured there were systems in place to submit required information to external organisations, such as surgical site infection data and numbers of alert organism infections and the Care Quality Commission (CQC) for notification of Deprivation of Liberty Safeguards applications.

Most staff had access to information technology (IT) systems to enable them to provide care and treatment to patients. The electronic patient record system had almost completely been rolled out at this location and staff believed this had been a positive improvement in the management of information for patients. Staff were aware of how to use and store information securely and confidentially. We did not observe any computers being mis-managed during our inspection.

Engagement

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

Staff participated in the trusts staff survey. The most recent survey closed in November 2022; however, the results were not due to be published until February 2023. The results from the 2021 staff survey (published in 2022) remained the current results in place. Information showed the results for 1,099 staff members which was 14% of the trust responses.

Medical care (including older people's care)

The results demonstrated a varied level of satisfaction and dissatisfaction with the trust. Areas of the worst outcome were in relation to there being enough staff to enable them to complete their job (17% agreed with this) and only 10% of staff not thinking about leaving their role. In addition to this, 45% of staff answered they would recommend the organisation as somewhere to work and 51% would be happy for a member of their family or friends to be treated at the organisation. Some of the most positive responses included 98% of staff not experiencing any physical violence form their work colleagues and 92% feeling trusted to do their job. The results of this survey were reviewed by managers and an action plan put in place to address the issues identified.

The trust had a patient, carer and community council which regularly conduced reviews of the ward areas. The last review at Good Hope Hospital was conducted on Ward 8 on 25 November 2022. The verbal feedback received was very positive however, the formal report was yet to be shared with the trust.

The patient experience team reported patient feedback and engagement results by hospital, division, ward and specialty across a range of forums. Gathering the views of patients and their relatives was seen as an important measure in shaping the service. The patient experience team regularly met with patient experience groups to gather the intelligence from them and provided feedback to divisions monthly. The service also used the national inpatient survey to improve the services for patients.

The trust engaged with staff and listened to their concerns. In response to what had been discussed, the trust had provided many supportive features which included clothing and food bank access, homelessness support, staff counselling and menopause support. Despite this, positive engagement with staff completed by the trust, staff did not discuss this with the inspection team during our visit.

There were closed social media groups for all staff at the trust to join and engage with each other. Staff also told us of closed social media accounts created for their local teams. In addition to social media groups, the trust produced a newsletter to communicate trust news with staff.

Learning, continuous improvement and innovation

All staff were willing to continually learn and improve services. However, many staff were focused on the demands of the service which did not provide much opportunity to participate in any quality improvement programmes.

Some staff we spoke with were positive about ways in which improvements could be made in the delivery of the service. They believed they would be supported to take these ideas forward however, some staff were not aware of how to raise their suggestions, where some staff felt they just did not have the time to drive the improvements forward.

The trust as a whole were very proactive in research. Recent newsletters sent out across the trust highlighted another research programme which had been selected for funding which was in collaboration with the local university.

Areas for improvement

MUSTS

- The trust must ensure that the service has sufficient numbers of suitably qualified, competent, skilled and experienced staff to provide safe care and treatment to patients. (Regulation 18 (1) Staffing).

Medical care (including older people's care)

- The trust must ensure there is a process in place for all medical patients admitted on a non-medical ward to receive timely care and treatment from medical staff. (Regulation 12 (1) (2) (i) Safe care and treatment).
- The trust must ensure all patients have their nutritional needs assessed and met. (Regulation 14 (1) Meeting nutritional and hydration needs).
- The trust must ensure all staff are suitably trained and competent to provide safe patient care and treatment. (Regulation 12 (1) (2) (c) Safe care and treatment).
- The trust must ensure all staff receive appropriate supervision, professional development and appraisals to enable them to carry out their duties they are employed to perform. (Regulation 18 (1) (2) (a) Staffing).

SHOULDS

- The trust should ensure the current model in place to improve patient flow is implemented safely across the service. (Regulation 12 Safe care and treatment).
- The trust should ensure the premises are safe for use and emergency exits are not prevented from being used. (Regulation 12 Safe care and treatment).
- The trust should ensure all equipment checks including resuscitation equipment are regularly and accurately completed. (Regulation 12 Safe care and treatment).
- The trust should consider how they ensure patients are kept safe from avoidable harm from an infection.
- Both the trust and service leads should consider how to improve the culture within the service to ensure patient care and treatment does not become compromised.
- The service should consider how they ensure patients confidentiality is maintained at all times.
- The service should continue to increase awareness and implement the Accessible Information Standards.
- The service should continue to improve the care provided to patients living with dementia which includes improving the environment.

Our inspection team

We inspected the service on the 13 and 14 December 2022 and completed a number of interviews off site after these dates. The inspection team comprised of a lead inspector, a mental health inspector, a pharmacist specialist inspector, an assistant inspector, a specialist advisor with a nursing background in medicine and an expert by experience. An inspection manager oversaw the inspection.

During our inspection, we visited Wards 8, 9, 11, 14, 15, 23, MAU (Medical Assessment Unit), AMU (Short Stay Medical) and the Endoscopy Department. Unfortunately, we were unable to visit Wards 10 and 12 as these were closed due to infection prevention and control reasons.

We spoke with 26 patients, 4 relatives and 52 members of staff. These included service leads, matrons, nurses, consultants, junior doctors, nurse associates, allied health professionals, healthcare assistants, domestic staff and ward clerks. We observed care and treatment and looked at 32 complete patient records and an additional 12 medicine 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.