Lewisham and Greenwich NHS Trust

Queen Elizabeth Hospital

Inspection report

Stadium Road
Woolwich
London
SE18 4QH
Tel: 02083333284
www.lewishamandgreenwich.nhs.uk

Date of inspection visit: 7 & 8 December 2022
Date of publication: 22/02/2023

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 Queen Elizabeth Hospital

Inspected but not rated

Queen Elizabeth Hospital (QEH) is one of two hospital locations operated by Lewisham and Greenwich NHS Trust. The trust provides acute and community healthcare services to people living in the London boroughs of Lewisham, Greenwich and Bexley.

The hospital has 521 beds and services include accident and emergency, medical, surgery, critical care, maternity and gynaecology, services for children and young people, outpatients and diagnostic imaging.

We carried out an unannounced focused inspection of the medical division at QEH because we received information that gave us concerns about the safety of the service and nurse staffing levels. The trust had also performed poorly in the last NHS Adult Inpatient Survey (2021).

We found:

- There was an increased number of nursing staff to safely care for patients.
- Staff were caring and compassionate. Staff provided emotional support to patients, families and carers to minimise their distress. They understood patient's personal, cultural and religious needs.
- Staff were positive about their ward leaders and trust leaders. They told us they were visible and approachable.
- The service had created action plans and a patient experience initiative to address areas of concerns raised by patients in the NHS Adult Inpatient Survey (2021).

However:

- Some staff had not completed their mandatory training or had their yearly appraisal.
- Staff did not complete falls risk assessments or pain assessments for all eligible patients

At our last inspection in July 2020, we rated medical care (including older people's care) at QEH as requires improvement for safe and good for effective, caring, responsive and well-led (good overall).

We did not rate this service at this inspection. The previous rating of good remains.

How we carried out the inspection

On the inspection we visited 6 wards. These included a care of the elderly ward, an acute medical unit admissions ward and general medicine wards. We focussed on safe, caring and well-led with some aspects of effective and responsive

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

Medical care (including older people's care)

Inspected but not rated

We inspected this service but did not rate it. The previous rating of good remains. We found:

- The service had enough staff to care for patients and keep them safe. Most staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment and gave patients enough to eat and drink.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. 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.

However,

- Not all staff were up to date with their mandatory training including safeguarding training.
- The service did not always carry out or record pain assessments for elderly and vulnerable patients.
- The service did not always carry out falls risk assessments for eligible patients.
- Not all staff had received their yearly appraisal for monitoring performance and identifying areas of learning.

Is the service safe?

Inspected but not rated

We inspected this service but did not rate it. The previous rating of requires improvement remains. We found:

Mandatory Training

The service provided mandatory training in key skills to staff. However, not all staff were up to date with their mandatory training.

Nursing staff told us they received and kept up-to-date with their mandatory training. However, training completion rates for staff were below the trust target of 90% at 85.6%. Medical staff were the worst performing group of staff members in the medicine division as they had only completed 75.2% of their mandatory training.

The mandatory training was comprehensive and met the needs of patients and staff. Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Medical care (including older people's care)

Managers monitored mandatory training and alerted staff when they needed to update their training. Some staff told us they were given time to complete training. However, not all staff were given this opportunity and had to complete training in their own time.

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. However, not all staff were up to date with safeguarding training.

Nursing staff and medical staff received training specific for their role and were able to describe how to recognise and report abuse. However not all staff were up to date with safeguarding training. For example, staff on Ward 19, a care for the elderly ward, had a completion rate of 73.3% for safeguarding training and rotational medical staff had a completion rate of 61.5% against a target of 90%.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults at risk of, or suffering, significant harm, make a safeguarding referral and worked with other agencies to protect them.

Information on who was in the safeguarding team for the hospital was on display on wards that we visited.

Cleanliness, infection control and hygiene

The service generally controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. However, the service did not always complete regular audits of infection prevention control (IPC).

Completion of IPC audits was variable. Audits were not completed regularly and not all wards participated in all the categories. Only two wards out of 17 had undertaken a personal protective equipment audit in the three months prior to inspection and only five wards had completed an audit into hand hygiene and isolation rooms. Ward 23 scored 50% in a commode audit in September 2022. This has not been audited since. Ward leaders told us that they were aware of the importance of completing audits but struggled to complete them due to pressures of the ward where they had to assist staff in caring for patients.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Each ward had its own IPC display board. This board displayed information on hand washing techniques information on the flu and infection control champion.

We observed staff on each ward following infection control principles including the use of personal protective equipment (PPE) and washing their hands before and after patient contact.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

There had been zero cases of hospital associated MRSA bacteraemia and 17 total hospital-associated *Clostridioides difficile* (*C.difficile*) cases during April to November 2022. This was below the NHS mandated threshold.

Medical care (including older people's care)

Environment and equipment

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

Patients could reach call bells and staff placed them close to the patients after each interaction.

Side rooms were available to patients who needed them including those who needed to be isolated.

Wards we visited had separate male and female bays with toilets and washing facilities in each bay. However, in one ward, patients who received day care treatment could be treated in a mix sex bay. There had been no complaints or incidents raised about this practice.

Entry into and out of the ward was secure with swipe access to maintain a secure environment. Visitors accessed the ward using a call bell, which enabled staff to monitor visitors and patients entering the wards.

Staff carried out daily safety checks of specialist equipment. This included safety checks of specialist equipment such as resuscitation trolleys.

The service had enough suitable equipment to help them to safely care for patients.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The National Early Warning Score (NEWS2) was used in the service to identify patients at risk of deterioration. We sampled 6 patient records and saw regular checks of patient's status and that escalation had taken place when required.

We sampled patient records across medical and elderly wards and saw 4 out of 6 patient records were up to date with risk assessments and care plans. However, we found 2 patients without their assessments completed and reviewed regularly on their records. This was raised with staff who informed us that one patient had only just been admitted to the ward and was due to be assessed. The other patient was a young mobile patient who had their initial assessment completed but no further review. Staff told us that this was because they were a low-risk patient.

The service conducted audits into risks assessments to ensure they were being completed on admission including venous thromboembolism (VTE), falls and malnutrition.

The service completed 98% of assessments for VTE in October – December 2022 which was above trust target.

However, the service had not completed falls risk assessments for all eligible patients on admission. From data provided by the service, on Ward 20 in November 2022, the ward only conducted 15% of patients falls risk assessments on admission. The average rate of completion of falls risk assessments across all medical wards was 44.07% in the previous three months. There is a risk that not all patients who were vulnerable to falls had been identified.

We asked for malnutrition risk assessment data but did not receive it.

Medical care (including older people's care)

There was a clear pathway for the management of Sepsis. Sepsis is a potentially life-threatening illness when the body's response to infection injures its own tissues and organs. Medical staff were able to describe signs and treatment of Sepsis within the national guidance.

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. We observed board rounds on two wards which were consultant led and saw there was detailed discussion about individual patients' treatment and needs.

The service had access to a mental health team to help provide support to patients requiring it.

Nurse staffing

The service had 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 and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Staff told us that they felt staffing levels had improved since the service had carried out the annual safe staffing review and increased staffing levels on the wards in the previous months. On the day of inspection, staffing levels were rated amber across the whole medical division, meaning staff levels were not optimal but were safe. The trust told us that as of November 2022, they had fully recruited to all band 6 nursing positions that were needed to ensure at least one band 6 nurse on each shift on each ward.

Although data provided showed gaps in some unfilled shifts, the number of nurses and healthcare assistants matched the planned numbers on all wards we visited on the day of inspection. For example, on ward 19 the ward had five nurses and five healthcare assistants present on the ward vs a planned target of four nurses and four healthcare assistants. This included at least one experienced nurse to support other less experienced nurses.

The service held a daily safe staffing meeting with all ward managers and matrons to discuss the next 24 hours of staffing within the wards. They could adjust staffing levels and skill mix daily according to the needs of patients at these meetings.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. Rotas were filled six weeks in advance. Any issues or gaps in the rota in relation to skill mix were escalated to the matron.

The service had low vacancy rates for health care assistants and nurses.

The service had high sickness and turnover rate for health care assistants. The health care assistant sickness rate was 7.85% against a target of 4% and had a turnover rate of 17.36% in November 2022 compared to a target of 12%. Nursing staff sickness and turnover were on or below target with no trend.

The service made regular use of bank and agency nurses on the wards to cover sickness and vacancies. Managers made sure all bank and agency staff had a full induction and understood the service. Managers block booked agency staff when required to ensure familiarity with the service. Staff showed us induction checklist for bank staff which information on equipment, patient care, procedures and safe working on the wards. New starters received a welcome induction pack.

Medical care (including older people's care)

Divisional leads told us that recruitment was always ongoing and nurse staffing remained on the risk register. The service was in the process of recruiting international nurses which took time. However, retention was a challenge as staff were offered development opportunities and staff had moved to work in other divisions as this was seen as less demanding. Ward managers and staff told us that that increased establishments had already resulted in opportunities for promotion and training, which managers hoped would help keep staff in post.

Medical staffing

The service 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. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. The service had a good skill mix of medical staff on each shift and reviewed this regularly. On the day of inspection, the medical staff matched the planned number on the wards we visited. For example, on ward 14, two consultants led the ward round and were supported by two registrar doctors and four doctors in training. We reviewed actual medical staffing levels on all medical wards we visited for the previous 3 months, but we were unable to determine if safe medical staffing levels were being met on each shift.

The service also employed 20 physician assistants (PAs) who supported consultants with clerking in patients, diagnosing patients and ordering and interpreting tests. Medical staff we spoke to told us that PAs were very supportive on the ward including junior doctors who told us they especially supportive in their acclimatisation to each new ward when on rotation.

The service had reducing vacancy rates for medical staff. Vacancy rates decreased from 18.13% in October 2022 to 16.12% in November 2022 on medical wards. However, this remained above the target of 12%.

Sickness and turnover rates for medical staff were low on medical wards.

The service had used regular locum medical staff on the ward. Locum medical staff that we spoke to had worked regularly on the ward for the past 4 year.

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.

The service always had a consultant on call during evenings and weekends. Medical staff told us they were able to contact a consultant if required during out of hours.

Records

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

We sampled patient records and patient notes were comprehensive and all staff could access them easily. Patient's medical and care notes were electronic and stored securely.

When patients transferred to a new team, there were no delays in staff accessing their records. When patients moved from ward to ward, staff could electronically access medical notes and assessments. We observed that computers were locked when not in use.

Medical care (including older people's care)

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Medicines were prescribed electronically by medical staff and checked by pharmacy staff.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Staff completed medicines records accurately and kept them up-to-date. We saw detailed notes on patient records of communications with patients surrounding their medicines. Patients told us that staff involved them in conversations about their medicines.

Staff mostly stored and managed all medicines and prescribing documents safely. The medicines rooms were stocked and clutter free. The rooms were only accessible to staff through a keycode locked door and the medicines were kept locked in cupboards. However, on Ward 14 we found an error in the controlled drug register where a patient's controlled medicine could not be accounted for. We made the ward manager aware who investigated. It was found that staff had not correctly updated the register when it was given to the patient on discharge.

Staff learned from safety alerts and incidents to improve practice.

Incidents

The service managed patient safety incidents well. Staff mostly recognised and reported incidents and near misses.

Staff we spoke with were able to describe how to report incidents and concerns. Staff told us they were also comfortable raising issues with ward leaders. Staff were able to receive feedback from incidents once any investigations had taken place.

However, on Ward 21 staff did not recognise a potential mixed sex accommodation issue where a male patient was being treated for the day in a female only bay. It was unclear how this was managed in terms of oversight and making patients aware that they may be cared for in a mixed sex bay.

Managers understood their obligations under Duty of Candour (DoC). This statutory duty, under the Health and Social Care Act (Regulated Activities Regulations 2014) requires providers of health and social care services to notify patients (or other relevant persons) of certain safety incidents and provide them with reasonable support.

Is the service effective?

Inspected but not rated

We did not rate this service at this inspection. The previous rating of good remains.

Medical care (including older people's care)

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients told us that staff met their needs for nutrition and hydration and they encouraged them to eat and drink. Patients told us they were able to get more food if they requested it.

We sampled 6 patient records and saw that staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Pain relief

Staff assessed and monitored most patients regularly to see if they were in pain and gave pain relief in a timely way when requested. However, they did not support those unable to communicate using suitable assessment tools.

Staff gave pain relief to patients when requested. However, in patients' medical records that we sampled on care of the elderly wards, staff did not assess patients' pain using a recognised tool for patients that could not effectively communicate pain including patients who had dementia and Parkinson's disease. It was unclear how staff managed these patients to ensure they were not in pain.

Staff administered and recorded pain relief accurately when it was requested.

Competent staff

The service made sure staff were competent for their roles. Most staff received appraisals from managers. Managers held supervision meetings with staff 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. Managers showed us examples of completed induction booklets for new staff that included learning and supervision of clinical and administrative tasks required to work on the ward. Staff told us they felt supported by ward managers and other experienced staff.

Staff told us managers supported nursing staff to develop through regular, constructive clinical supervision of their work. They had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Staff told us they received regular appraisals discussing performance, learning and career opportunities. However, nursing staff had an appraisal rate of 80.3% against a target of 90%. This had not improved in the six months prior to inspection.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff had an appraisal rate of 92%.

Medical care (including older people's care)

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us managers supported learning on the ward and were available for knowledge and procedure support if staff were unsure. Staff were encouraged to apply for external training by leaders.

Managers made sure staff received any specialist training for their role.

Is the service caring?

Inspected but not rated

We did not rate this service at this inspection. The previous rating of good remains.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff mostly took time to interact with patients and those close to them in a respectful and considerate way. In areas we visited, we observed staff interacting positively with patients. However, on one ward, we were approached by a patient relative who raised concerns that staff were ignoring her requests for her partner to be attended to by the doctor. We raised this to the nurse in charge to attend the patient.

Most patients said staff treated them well and with kindness. We spoke with 14 patients across 4 wards and all described their experience of care positively and told to us ‘the staff are brilliant’, ‘the staff are very caring’, and ‘the staff are lovely’.

However, on another ward, one patient raised a concern to us of witnessing night staff being rude to a patient in the middle of the night. We raised this with the nurse in charge to investigate.

All patients told us that their hygiene and nutritional needs were being met. Most patients told us that staff responded quickly to call bells. However, two patients told us that the call bells were not answered quickly enough which led to incontinence.

Staff followed policy to keep patient care and treatment confidential. Information about patients was either anonymised when in public view or covered by a blind when not in use. Staff made use of curtains around beds to ensure patient privacy when needed, especially when patients were waiting in the corridor before being admitted to the ward.

Staff displayed thank you cards from patients and relatives for the public to view. We observed staff receiving gifts of chocolate and cards from patients thanking them for their good experience of care.

Staff 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 saw staff on inspection interact in a caring way with a patient who had delirium. They reassured the patient they were safe and escorted them back to their bay.

Medical care (including older people's care)

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

The service had identified noise at night as an area of concern arising from the last NHS adult inpatient survey (2021). This aspect had been incorporated in improvement plans as part of a newly introduced patient experience strategy (2022-2025) and the trust was trialling noise monitors that alerted staff whenever levels were too high. Patients we spoke with said that noise at night was minimal.

Emotional support

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

Patients and their relatives told us staff gave them emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We observed staff assist a patient who repeatedly was shouting for help but had already been helped. Staff were kind and reassuring to the patient.

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.

Understanding and involvement of patients and those close to them

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

Patients mostly gave positive feedback about the service. Patients told us that they felt cared for and nurses were attentive and supportive. However, staff only sometimes made sure patients and those close to them understood their care and treatment. Patients on some wards told us they felt well cared for but did not always understand their treatment.

Other patients told us that when staff shared information with them, they talked in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this through the Friends and Family test. The friends and family test is an optional survey for patients and relatives to fill out at the end of their stay describing if they would recommend the care they received for their friends and family. All the wards we visited scored above 90% in the previous 3 months before the inspection. The ward average score in October 2022 was 95.56%

Is the service responsive?

Inspected but not rated

We did not rate this service at this inspection. The previous rating of good remains.

Medical care (including older people's care)

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

Wards were designed to meet the needs of patients living with dementia.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff could refer patients to the service's dementia team to help provide for their needs and provide enrichment activities such as going for walks or playing games.

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

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Translation services, if needed were booked via the trust's language line.

Patients were given a choice of food and drink to meet their cultural and religious preferences. The service had recently trained their nutritional support assistants on suitability of menu choices for specific diets including halal and kosher diets.

The service had suitable facilities to meet the needs of patients' families. The wards had day rooms where family members could relax with patients outside of their bay or usual room.

Access and flow

People could access the service when they needed it and received the right care promptly. The trust faced significant challenges when planning patients' discharge, particularly for those with complex social care needs.

The service had introduced a new trial project called the 'Woolwich Way' based on a model used elsewhere in the NHS. This project involved increased flow of patients from the admissions department to the ward to encourage discharge and allow for safer care of patients on the ward than in the emergency departments. Eligible patients were given letters detailing the trial so that they understood what would happen. Due to the nature of the trial, staff told us that this added pressure to the ward as it meant an extra patient was monitored on the ward corridor before being admitted. The service held safety meetings three times a day to assess and address issues raised with the boarding method.

Managers and staff started planning each patient's discharge as early as possible. Patients discharge planning normally started on admission and only delayed if the patient was unwell and care needs could not be estimated when they would be better. Staff discussed discharges at board rounds and highlighted patients who were medically fit for discharge but did not have social care planning in place to be discharged safely.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. Staff described difficulties to us when planning patients' discharge, particularly for those with complex mental health and social care needs across the medical wards. Patients who were medically fit for

discharge whose discharge was delayed were escalated as per trust policy. However, we were told of challenges staff faced with patients who could not be discharged safely due to complex needs and requirements in the community. On Ward 19, 5 patients were medically fit for discharge but staff on the ward were unable to find suitable accommodation in the community for them to be discharged to. We requested data on the number of delayed discharges had, however this was not provided.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. Consultants told us they were able to care for patients in their speciality on non-speciality wards until there was a bed available in the speciality ward. They would visit these patients as part of their ward round. The service tried to ensure that patients were admitted as close to the relevant ward as possible to minimise time spent travelling between wards. We requested data on the number of patients that were cared for on non-specialty wards, however this was not provided.

Is the service well-led?

Inspected but not rated

We did not rate this service at this inspection. The previous rating of good remains.

Leadership

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

The medical wards were led by an acute speciality medicine leadership team which included a senior head of nursing, a senior general manager and clinical director. They were supported in each speciality by matrons, ward managers, service managers and clinical leads.

Leaders of the service held meetings three times a day to discuss the 'Woolwich Way' project. They discussed incidents and monitored safety on the wards.

Staff told us that ward managers and matrons were visible and approachable on the ward. Leaders of the service also regularly visited the wards to maintain visibility to staff, including at night.

Matrons were visible on the ward and were knowledgeable about the challenge faced in the wards that they oversaw.

Culture

Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The service had an open culture**.** Staff told us they felt comfortable challenging senior staff in patient discussions and approaching leaders with issues that they had.

Most staff we spoke with showed awareness of freedom to speak up guardians should they need to raise a concern. Freedom to speak up guardian information was displayed on each ward. The service displayed on their website the full years report of issues raised with the freedom to speak up guardians and what they had done to address issues.

Staff told us they felt supported by the leaders. All staff spoke highly of the ward managers assisting them in their day to day clinical roles and also with their professional development. Staff felt they could raise issues on the ward to the ward managers and matrons without fear. Wards that we visited showed us their unique ways of celebrating staff including personalised certificates for staff highlighting their strengths and achievements from throughout the year.

Leaders supported staff to develop their skills and take on more senior roles. The service provided opportunities for staff recruited locally and those recruited from oversees to progress. Matrons that we spoke to had recently been promoted from ward managers.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Leaders were able to describe the challenges that the service faced, including safe staffing levels. The service met regularly to discuss these risks and challenges, and these were documented in the risk register. There were controls in place to mitigate the risks and there was a named member of staff responsible for each risk. However, the service had not actioned all risks in a timely manner. The service had identified an increase in falls in July 2020 where they acknowledged a lack of timely risk assessments relating to falls. The latest updates on the risk showed the number of falls with harm had reduced in August 2022. However, the trust had only completed 44.07% of falls risk assessments on patients in September to November 2022.

Leaders on the ward held daily huddles where risks and issues with patient safety were discussed by staff. Learning specific for doctors was shared during the consultant led ward rounds.

The service leaders led a quarterly learning event with incidents presented by staff members on the ward to discuss learning and actions to take going forward. Leaders told us it was well received and attended.

Engagement

Leaders and staff actively and openly engaged with patients, staff and the public to plan and manage services.

Leaders told us they held drop-in sessions for staff to attend and give feedback.

The service had organised a patient forum in early 2023 to get feedback from patients surrounding the care they received in the service.

Managers were supportive of staff in career progression and acknowledged when staff performed well. Each ward we visited had a unique way of celebrating staff success. One ward manager showed us certificates that they had made for the ward staff celebrating their success and strengths throughout the year.

The trust had recently started a patient experience programme to address issues raised through the NHS Adult Inpatient Survey (2021) and through complaints received about patient experience of care. It aimed to enhance the insight,

Medical care (including older people's care)

involvement and improvement of the patient experience. Themes that are currently being addressed are listening and learning from patient feedback, establishing links with staff, patient and carer involvement in designing initiatives in improving care and enhancing spiritual care and the volunteers service. The work was in the early stages at the time of the inspection.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Queen Elizabeth Hospital – medical care (including older people's care)

- The trust must ensure that staff complete a falls risk assessment for all eligible patients on admission to assess and mitigate risk for patients who are at risk of falls.

Action the trust SHOULD take to improve:

Queen Elizabeth Hospital – medical care (including older people's care)

- The service should ensure that staff carry out and record pain assessments for all patients who struggle to communicate pain.
- The service should ensure that mandatory training compliance rates meets trusts targets.
- The service should ensure that all eligible staff receive appraisals in line with trust targets.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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