University Hospitals Birmingham NHS Foundation Trust

Inspection report

Queen Elizabeth Hospital Birmingham
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Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Inadequate**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

University Hospitals Birmingham NHS Foundation Trust is one of the largest teaching hospital trusts in England, serving a regional, national and international population. It includes running four major hospitals: Birmingham Heartlands Hospital, the Queen Elizabeth Hospital Birmingham, Solihull Hospital, and Good Hope Hospital. It also runs a number of community services, including the Birmingham Chest Clinic, the Norman Power Centre and the Washwood Heath Community Diagnostic Centre.

The trust sees and treats more than 2.2 million people every year and employs around 24,600 members of staff.

The trust is a regional centre for cancer, trauma, renal dialysis, burns and plastics, HIV and AIDS, as well as respiratory conditions like cystic fibrosis. It also provides services in premature baby care, bone marrow transplants and thoracic surgery and has the largest solid organ transplantation programme in Europe. It also provides specialist cardiac, liver and neurosurgery services to patients from across the UK.

The Queen Elizabeth Hospital Birmingham has been designated both a level 1 trauma centre and host of the UK's National Institute for Health Research (NIHR) Surgical Reconstruction and Microbiology Research Centre (SRMRC).

This was a trust which had been through a period of substantial change in recent years. This has included the merger (by acquisition) in 2018 of two large NHS Birmingham-based trusts to form University Hospitals Birmingham NHS Foundation Trust. A new Chief Executive Officer took the interim role in January 2023 and was confirmed into post in July 2023. Other executives have left the organisation this year, or will leave in the course of 2023. There is therefore a relatively new and changing board of directors and a number of the non-executive directors are recent appointments. A new Chief Operating Officer has been appointed but not yet taken up their post. A couple of the long-standing non-executive directors are coming to the end of their term, so more new appointments are expected. The Chief Medical Officer will step down from their role to take up a nephrology and research role in the trust later in 2023 and recruitment was underway for their replacement.

Our findings

To add to these changes, the trust is at the beginning of a major transformation of its operating model. The trust board recognised that the governance of a trust of this size being based around seven cross-cutting divisional structures needed to be revised. The trust is now in the early stages of the new structure, rolled out in phase one at the start of October 2023. This will place the responsibility for local governance, quality and safety with a hospital-based leadership model. Each hospital will have its own senior leadership team, led by an executive director. These teams will have devolved responsibilities from the main trust board (to be known as the 'group' board) to run and manage most clinical services at site level. Some teams will remain reporting through to the group board and not devolved to hospital level with some services remaining on a shared-service basis such as pharmacy and pathology.

The trust has been subject to some intense media scrutiny in the past couple of years, mostly around areas of culture, bullying and harassment. This culminated in the recent publication (September 2023) of a culture review by an external company commissioned by the trust chair.

The trust has undergone an extensive capital investment programme including seven new hospital wards, a new cardiology daycase unit at Good Hope Hospital, and a treatment centre at Heartlands Hospital for 1,500 patients to be treated every day. It has opened an improved treatment centre in Solihull and a diagnostic centre in Washwood Heath, due to open in January 2024.

Our inspection in August and October 2023 included a focused review of critical care services at the Queen Elizabeth Hospital Birmingham, and a focused review of well-led. Critical care was limited to the key lines of enquiry around safety and leadership (well-led). Our well-led inspection focused on four of our key lines of enquiry, namely leadership; culture; governance; and management of risk, issues and performance. We recognise the trust would have provided evidence of groundbreaking and innovative care and treatment had we explored our other key lines of enquiry. However, this review was limited to these four specific areas following serious concerns raised by stakeholders and recent culture reports.

We carried out core-service inspections between February and July 2023 in maternity services, urgent and emergency care, medical care, and two focused inspections of specialist services (cancer and neurological services). In these inspections we rated as follows:

At the **Queen Elizabeth Hospital Birmingham** we inspected and rated:

- Urgent and emergency care rated as requires improvement overall with an inadequate rating for safe. Effective, responsive and well-led were requires improvement and caring was good.
- Neurological services rated as requires improvement overall with an inadequate rating for well-led. Safe, effective and responsive were requires improvement, and caring was good.
- Cancer services (focused inspection) rated as require improvement overall. We inspected safe and well-led, both of which were rated as requires improvement.
- Critical care (focused inspection) rated as requires improvement overall. We inspected safe and well-led, both of which were rated as requires improvement.

At **Birmingham Heartlands Hospital:**

- Urgent and emergency care rated as requires improvement overall (revised from an inadequate rating) with an inadequate rating remaining for safe. Effective, responsive and well-led were requires improvement and caring was good (improved from requires improvement).

Our findings

- Maternity services (focused inspection) rated as inadequate overall. This was a follow-up inspection from a warning notice served and did not change the ratings.

At **Good Hope Hospital:**

- Urgent and emergency care rated as inadequate overall with inadequate ratings for safe and well-led. Effective, caring and responsive were requires improvement.
- Medical care (focused inspection) rated as inadequate overall with inadequate ratings for safety and well-led. Well-led was revised from requires improvement to inadequate at this inspection.

During our focused well-led inspection, we spoke with many of the trust executive directors, almost all of the non-executive directors, in a group call, and held focus groups and interviews with staff and network leaders. A number of staff contacted us both prior to, during and after the inspection with information of concern. However, despite this inspection being announced several weeks in advance, we were disappointed with the number of staff who chose to come and meet with us, either face-to-face or on a web-based call. We were told by the staff we did meet, that many of their colleagues were not aware of the meetings or they had been unable to join due to it clashing with other responsibilities. A number of staff also told us they did not have access to computers or an office where they could have a private conversation. Nevertheless, we recognised staff were busy, may have been unable to make one of the limited times on offer, and we were also only available face-to-face on one site due to time and resource pressures.

How we carried out the inspection

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

Use of resources

The use of resources was not inspected on this occasion.

Combined quality and resource

The combined quality and resource was not inspected on this occasion.

Outstanding practice

We found the following outstanding practice:

- There was outstanding and fairly unique support by the wellbeing service given to staff who found themselves unintentionally homeless in the current cost of living crisis. The trust board and the wellbeing team recognised the damage this situation did to often low-paid workers and was able to provide support so no staff ended up with nowhere to sleep.

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.

Our findings

Action the trust MUST take to improve:
We told the trust that it must take action to bring services into line with two legal requirements.

Trust wide:

- The trust must resolve the longstanding issues with culture, staff wellbeing and staff safety and any form of unacceptable behaviour in all the forms described in this report. The trust must find a mechanism to bring staff who have experienced the poor culture to be the driving force for change and find a way to make that safe and secure for staff. This includes the post-graduate doctors in training. It must make the environment for staff in which this takes place free of judgement and blame. In doing this, the trust will ultimately allow staff to be their best and bring safe and quality care for the patients and public it serves. Regulation 18(2)(a): Staffing.
- The trust must review, support and strengthen the role of the Freedom to Speak Up Guardian, including implementing the proposed or preferred local model at sites, and looking towards a more grass-roots and simplified structure. It must ensure all staff are protected by the process when concerns are shared confidentially beyond the office of the Guardians and entrusted to managerial staff. Concerns must be addressed in a timely and respectful way. It must consider the reflection and planning tool and self-reflect on the service as indicated by NHS England and the National Guardian's Office. This includes reviewing all requirements as laid out for executive and non-executive directors, the chief executive officer, and the Freedom to Speak up Guardian. This guidance was relaunched in 2022 and the trust board are required to approve the self-reflection by January 2024 at the latest. Regulation 17(2)(a): Good governance.
- The trust board must have qualitative assurance of learning and measurable improvement when things go wrong. This includes learning from serious incidents, complaints and avoidable deaths. It is insufficient to present numbers of instances but no themes or learning and evidence of subsequent change. The board must take assurance from improvements and actions which have measures, objectives and aims to demonstrate learning and change is valued, demonstrable and constant. Regulation 17(2)(a)(b): Good governance.
- The trust must ensure the board are assured about the competence, experience and skills of the workforce to deliver the regulated activities. This includes assurance around mandatory training, competency training, and appraisals of all staff. Regulation 18(1): Staffing.
- The trust must ensure the people (HR) department has the resources and resilience to deal with the issues of culture and supporting fast and effective recruitment. The effective function of the people department must concern the board to provide assurance of a protected and resilient workforce. Regulation 18(2)(a): Staffing.

Queen Elizabeth Hospital Birmingham Critical Care:

- The trust must ensure it assesses, implements and improves the quality of care provided by ensuring the mandatory and legally required training meets the needs of staff and patients, and that it is completed by all relevant staff. (Regulation 17(2)(a): Good Governance).
- The service must ensure measurable action is taken to address the bullying and cultural concerns within the service to prevent impacting safe care and treatment. (Regulation 17(1) : Good governance).
- The trust must ensure there is an effective risk and governance system to support safe, quality care and drive improvements with quality and risk assessments. (Regulation 17(1): Good governance).

Our findings

Action the trust SHOULD take to improve:

Trust wide:

- The trust should consider improved promotion of the wellbeing service for staff and all that it provides to support the workforce.
- The trust should consider improving the board report from the Guardian of Safe Working to show context and trend analysis of exception reporting. There should be data presented on rota gaps and the plan to improve these should be part of the trust's quality account.
- The trust should consider how it demonstrates to the Governors that their views are being heard.
- The trust should consider how it can reduce the length of time taken to investigate serious incidents so that learning and training, if needed, can be more rapidly undertaken and understood.
- The trust should consider how it represents all key performance measures in board reports and provides useful and considerate comparison to determine if risks are emerging or escalating.
- The trust should consider whether it meets all legal requirements when recruiting staff and meeting the obligations for senior staff of the Fit and Proper Persons Regulation.

Queen Elizabeth Hospital Birmingham Critical Care:

- The trust should ensure that action is taken to improve the safe handling and management of medicines.
- The trust should ensure the current model of staffing does not place patients at risk of harm by not having enough suitably qualified, competent, skilled and experienced staff caring for them and is not overly reliant on external staff.
- The trust should ensure all equipment checks are regularly and accurately completed, and any concerns escalated in line with trust policies.
- The trust should ensure all medical staff receive an appraisal.
- The trust should ensure action is taken to improve infection prevention and control practices within the service to reduce the risk of harm to patients from transmissible infections.
- The trust should consider how they assure themselves they provide care and treatment in line with national sepsis standards.

Is this organisation well-led?

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

Leadership

Although there were the beginnings of change and recovery, and recognition of present and past concerns, there had not yet been sufficient time to demonstrate progress to for leaders to show they were dealing with the risks, issues and challenges in the service and how to resolve them effectively. Leaders had not yet ensured the mechanism for good leadership provided them with the reality of lived-experience for their staff. This particularly related to matters of staff safety, unchallenged or hidden bullying cultures, and a fear of speaking up. Throughout the organisation, not all leaders demonstrated they had the skills to be effective leaders and to protect staff from discrimination.

Our findings

However, there were notable improvements in senior leaders becoming more visible and approachable in the trust for patients and staff.

Most staff we met said they knew who the leadership team were and they had become more visible and approachable. This was particularly after needing and finding new more wide-ranging communication channels during and after the pandemic. Staff talked about the regular presentations by the Chief Executive as being good sources of information. However, not all staff had regular access to computers or emails and some said they therefore, found it less easy to keep up to date with news and developments or join online events. We did hear a lot of positive comments from almost all the staff we spoke with in focus groups, including administration staff, and more junior nursing staff, about their own managers and the support and particularly great teamwork they experienced.

Members of the board made visits to various parts of the hospital and attended events on a regular basis to meet staff and patients. For example, the trust Chair reported to the board in July 2023 they had visited a number of wards and departments including pharmacy at Birmingham Heartlands Hospital and the intensive care unit. The chair had also attended the trust's Windrush event, and celebrations for NHS 75. Members of the trust had spoken at the recent event to mark South Asian Heritage Month. The chair reported to the board in September 2023 they had visited the interventional radiology department with staff from NHS England's Workforce, Education and Training team (formerly Health Education England) and one of the new non-executive directors. The chair had also joined the patient safety visit at the maternity department at Birmingham Heartlands Hospital accompanied by the Chief Nursing Officer.

We spent some time in the company of the Chief Nursing Officer in clinical areas of Queen Elizabeth Hospital Birmingham. We met a wide range of staff on these unplanned visits. All the staff we met were positive and enthusiastic. We were impressed with how many staff the Chief Nursing Officer knew by name. The Chief Nursing Officer was welcoming of people and demonstrated pride in their staff and hospital. We saw passionate leadership skills in evidence.

However, with a trust of this size and complexity, there were range of opinions, experience and views of leadership. Some staff talked about the poor behaviours we describe in more detail in our Culture section below, going unchallenged by leaders. We were given confidential examples of how some difficult behaviours had gone unchallenged. Other staff mentioned this in general terms. The perception was of a fear from leaders of tackling staff who were felt to treat others unfairly or exhibited unacceptable traits. This included sexual safety and racism, but also staff feeling events from the past had never quite been reconciled or had been allowed to go without sanction.

Talking with a range of staff across many roles and layers of responsibility, a number had not engaged with or were not aware of training for managers on managing difficult behaviours. The trust had a number of training packages, bespoke and targeted, in relation to managing conduct. Staff had access to a website (open to the public) hosting stories and experiences from staff around leadership and 12 including masterclasses on key leadership challenges.

We met with almost all the trust non-executive directors and found a committed and caring group of people from a wide range of backgrounds with a vast range of experience and knowledge to carry out this function. We concluded they had the skills and experience to challenge the executive team and to hold them to account, although needed to consider how their assurance, specifically around culture and hearing directly from staff, was undertaken. There was recognition from the non-executive directors of how the organisation was moving at a fast pace to implement change and particularly the new structure of governance. The risks from this fast pace of change were understood and considered as acceptable to see major improvement. They told us the risks to this reorganisation not being carried out at pace were seen to be greater.

Our findings

We met with a team of trust public and staff Governors in their role established in 2016 by NHS England as part of the duties of NHS trusts designated as 'foundation trusts'. The key functions were to hold the non-executive directors to account; represent and report on the interests of staff, trust members, local communities and local people; and approve significant transactions. The trust Governors met every two or three months in a formal session with members of the trust board and non-executives. The meetings were held in public and minuted. At these meetings, the Governors were provided with extensive board papers and these were presented by the relevant member of the board.

However, one area we did hear about was the Governors not always feeling confident in their role in representing the feedback and interests from their staff, communities and trust members. There were some views shared with us of efforts to provide feedback, particularly from staff groups, and this was said to be not met with any response or action taken. Some of the Governors we met felt there was some information which was not shared with them at times, and they found out from other routes, particularly some of the culture concerns.

The work with inclusion of Governors was improving. There was a useful wide range of views and opinions from the Governors we met. Most felt the trust Chair and Chief Executive Officer were supportive to them, open and honest. The Governors recognised and highlighted some of the issues of concern well known to the trust from media reports and independent culture reviews. They were positive about the new structure and the direction the board of directors was taking and optimistic for the future in solving some of these issues more locally.

The new arrangement for board sub committees, chaired by the non-executive directors, were recognised as being a step forwards. They would bring subject-matter experts together to focus on areas which now included patient safety and quality, and people (workforce). A number of members sat on multiple committees, so they were able to see and comment on a wider view of issues and subjects.

However, some of the assurances received by the non-executive directors came from trust executives only or board reports where certain evidence (see Governance below) was missing or unreported. After the inspection, the trust told us the NEDs had other opportunities to see and speak with staff, including ward visits, chairing board committees, and being sponsor of staff networks.

At times and in some parts of the trust, there was a lack of support, guidance, and a disregard at times of trust values in order to engender consistent and reliable behaviours and culture. Some staff who met with us talked about how some of the tier of middle managers and those sitting below board level said they were perceived or told to be letting down the trust and to blame for a lot of the culture problems.

Although staff recognised there were pockets of poor management style and behaviour, most staff were committed and wanted to do their best. We were unable to find evidence which supported this view of middle management beyond anecdotal evidence or it being just perceptions. Those we spoke with in leadership roles (of all levels of seniority) brought everything back to the care of patients, which they said remained their priority.

There were challenges to the quality and sustainability of the pharmacy service which was primarily due to a national hospital pharmacy workforce shortage. This led to a reduced level of service to some areas. However, recruitment was ongoing, and the senior leadership team ensured all high-risk areas received a pharmacy service.

The Chief Pharmacist arranged formal drop-in sessions at each location to be able to gather views of staff. They acknowledged it was a challenge to be physically visible across all locations. The four clinical operation leads based at each hospital had overall oversight of operations and had an open-door policy to staff. They would escalate issues directly to the governance team.

Our findings

A talent management programme ensured there was succession planning between all grades of staff and a commitment to support staff training. For example, pharmacists were put through the non-medical prescribing programme which had helped to extend the seven-day service at the Queen Elizabeth Hospital Birmingham with further investment and roll out to the whole trust. This had been acknowledged as a good development opportunity and experience for pharmacists.

Culture

Although there were emerging and some genuine efforts to learn and improve, still a worrying number of staff across the organisation who felt they were not supported, safe, respected and valued. There was a genuine fear for some staff of speaking out and not all staff felt safe from bullying, harassment, in its many forms, misogyny, racism or other discrimination. There was evidence of the potential development of a closed culture. How staff were treated impacted on their wellbeing and this is recognised by NHS England and in academic healthcare management studies as having a detrimental effect on organisational effectiveness and the care of patients and each other.

We were told by staff in minority groups the organisation did not always promote equality and diversity in daily work and provide opportunities for career development. The trust did not have an effective open and safe culture where all staff could raise concerns without fear of retribution or a fear of a breach of their confidentiality.

However, staff were still focused on the needs of patients receiving care and in providing the best treatment, care and service they could. There was outstanding practice in support for staff experiencing temporary homelessness.

Not all staff felt supported, respected and valued. Although we acknowledge how many staff at the trust were committed to their role in patient care, there were some staff who were not feeling safe, able to speak up, or valued. We met and spoke with a number of members of staff who came forward and recounted their experiences at the trust or recounted to them from fellow colleagues as they remained anxious to speak up. The majority of these were women in senior roles throughout the organisation. They talked of experiencing bullying, harassment (in its many forms), intimidation, disrespect, and misogyny. A number of these staff told us they had spoken up in the past but had felt unsupported by the process or the organisation. A number reported feeling let down by the speaking-up process when it was passed to others to resolve, and some talked of being embarrassed with colleagues; felt their confidentiality had been failed; and some talked of taking the tough decision to leave the organisation. Some staff reported that they would not speak up again due to their poor experience of previously doing this.

The NHS Staff Survey 2022 asked staff to report on their morale, engagement and motivation at work. In all the questions about staff motivation, including if staff were looking forward to going to work and being enthusiastic about their job, staff responses were below (worse than) the NHS average and just a few percentage points away from the worst response in the peer group of 124 acute NHS trusts. Just 48% of UHB staff who responded (48% of 5,592 staff) said they would recommend the trust as a place to work. This was 8% lower (worse) than the national average and had declined each year over the last five years of the survey. In terms of morale, 38% of UHB staff who responded (38% of 5,601 staff) said they were thinking about leaving. This was 6% above (worse than) the national average and had increased each year over the last five years of the survey. There were 27% of 5,594 staff who said they would probably look for a new job in the next 12 months (national average 23%) and 21.5% of 5,582 staff who said they would leave as soon as they found another job (national average 17%).

Our findings

In the culture review published in September 2023, the summary concluded many staff did not feel valued and respected, often not feeling safe at work, and not connected to the wider organisation in which they served. Staff reported not having a voice that was heard or acted upon and it was impacting on their wellbeing. These were the themes shared with us by the women in senior roles who came forward and spoke with us. The survey conducted by the review team noted 53% of staff felt bullied and harassed and although 62% of staff said they knew how to raise concerns, only 16% said they felt the concerns would be taken up by their employer. The review described this indicator as "stark".

Some staff in focus groups held by CQC said they were anxious about speaking with us due to there being more senior colleagues present. A number told us how their mental and physical health had suffered, and others reported this on behalf of their colleagues whom they had supported. We heard from staff who said they were fearful of speaking up; several had been told or decided they would not be listened to or believed; and staff feared retribution and their careers being harmed. This included doctors in training. Staff in many senior roles including medical, nursing and managerial spoke candidly with us about the culture, concerns over sexual safety, and unchallenged hierarchical poor behaviours.

The 2022 NHS Staff Survey asked staff to report on matters of culture. In 2022, 26.2% of staff completed the survey. This was the lowest response rate among the peer group of 124 NHS acute trusts where the average response was 44% and the highest was 69%. The trust's staff response rate was 10% down on the previous year. The average change in response rates was a drop of 1.9%. A low response rate could be indicative of staff poor engagement. The board was aware of the low response rate and the Chief People Officer agreed with this conclusion around change needing to be recognised or people would simply not engage. The response rate still amounted to answers from just over 5,600 staff. This was a larger number of staff than some other NHS trusts overall. In terms of culture the survey reported:

- 11% of staff said they had experienced bullying, harassment or abuse from managers. However, this had marginally reduced (improved) in the last five years and was now much the same as the national average.
- 20% of staff said they had experienced bullying, harassment or abuse from other colleagues. This had stayed much the same in the last five years and was much the same as the national average.
- 44% of staff who had experienced harassment, bullying or abuse at work said they or a colleague reported it. This was worse than the national average of 47% and the lowest result for the last four years. It had never been above 50% of staff reporting this.

The trust leadership were aware of many of the concerns among staff. A recent culture review had been commissioned by the trust through an independent organisation. This was published in September 2023. This followed two other reviews commissioned by the integrated care system board into clinical safety and governance and delivered to the trust earlier in 2023. The culture review (September 2023) recommended to the trust senior leaders they take "responsibility…to listen, understand the workforce needs, and to take positive action."

Staff in pharmacy said there had been some challenging and difficult times particularly due to staff shortages and the pressure that caused on wellbeing. Some staff felt there was a lack of opportunities for flexible working, and it was becoming increasingly difficult to replace people due to the workplace pressures.

The trust had developed a 'trust improvement plan' which included areas such as performance and finance, but also culture and organisational development. The trust leadership recognised and stated in the trust improvement plan update to the board (by the trust Chair – 28 September 2023) that it was "anticipated that there will need to be a continued period of reconciliation and restoration with the organisation." The trust therefore acknowledged the actions

and improvements would take time and need commitment to change from everyone. The board were provided with the trust improvement plan (which was in a format almost impossible to read or follow on a computer screen) and there were sections describing evidence to show actions had been completed and to monitor effectiveness. These actions were all across various time periods in 2024.

In July 2023, the board of directors was provided with an update on areas of concern raised by the post-graduate doctors in training. A number of sources of information were used for the report including national surveys, internal surveys, the junior doctor forum, the Guardian of Safe Working, and NHS England's, Workforce, Education and Training division. All had indicated a declining level of satisfaction and other concerns. CQC also received information of concern from senior educators and staff. Concerns included:

- There was bullying and inappropriate behaviour reported in the workplace.
- High sickness rates among junior doctors.
- 70% of junior doctors had issues with rota management and workload intensity.
- 45% of junior doctors were not aware of welfare services.
- There was a medium to high risk of burnout indicated in the junior doctor workforce.
- There was a lack of adequate facilities for junior doctors to rest.
- Only 20% of junior doctors would recommend working at the Queen Elizabeth Hospital Birmingham.

Many of these issues and others were part of NHS England's 'eight high impact actions' to improve the working environment for junior doctors' which was not used in the trust or audited to determine improvement, even though available for many years. However, the trust reported an fairly extensive list of actions of a similar nature to the eight high impact actions, but did not report if these had been audited to determine if they had made the intended difference. The survey from the junior doctors laid out in this section does not provide evidence of an overall positive impact from the combination of these actions to improve wellbeing or work pressure.

In the trust's internal survey data of post-graduate doctors in training (junior doctors) on questions of workplace culture and civility, some of the key responses from junior doctors were these:

- 50% said they had felt bullied or intimidated at work.
- 53% said they had witnessed bullying or intimidation.
- 32% said they had encountered or witnessed misogyny or racism.
- 48% said they did not feel they could raise concerns without fear or reprise.

It was difficult to determine from the executive summary report to the board, what the concerns related to except "deterioration in satisfaction". None of the above data was included or described. One paragraph talked about the support mechanisms already implemented had not led to improvements (although did not describe what they were, or when they were introduced). They were only reported to have not addressed the concerns raised. A new and extensive action plan was provided to the board although it was undated and was incomplete. There were no progress measures or key performance indicators agreed by the board or presented to be able to determine if actions would have the desired outcome in future to improve the experience of junior doctors, particularly as they did not in previous efforts.

Our findings

Although leaders and staff understood the vital importance of staff being able to raise concerns without fear of retribution, this was not reflected in experiences of all staff. Also, not all appropriate learning and action from staff speaking up was observed or taken in a timely manner. This was reported in the Freedom to Speak Up Guardian Annual Report to the board 2022/23 (27 April 2023). The report stated: “there is considerable variation in the rapidity and effectiveness of actions taken to address concerns – from a matter of days to almost 4 years in some instances.”

There were concerns about confidentiality in the process. The September 2023 culture report highlighted how staff needed to continue speaking up “in the positive way we experienced throughout this review.” This corresponded with our experience of staff coming to CQC to recount their experiences, but saying they had lost confidence in being able to speak up in the trust. One of the reasons often mentioned was with feeling their confidentiality had been broken or not respected or how long things took to resolve or be addressed.

A number of staff told us they had approached the office of the Freedom to Speak Up Guardian (FSUG). Those staff we spoke with felt the process of speaking up through the official route was not well supported by the trust to foster respect or trust. This was reported in the culture review (September 2023) which also confirmed concerns raised with us about the lengthy process and resolution rarely being observed. In the Freedom to Speak Up report to the trust board in April 2023, the Guardian reported: “However, more complex and long-standing issues need to be referred to managers or executives and these can be difficult and time-consuming to investigate and some prove resistant to resolution. Some issues raised several years ago are still active". Due to the perceived limited resources within the human resources team, staff and managers often felt unsupported, and that the effective resolution of issues was often very protracted impacting on staff wellbeing.

We recognised through the policies and procedures underpinning the work of the FSUG how staff confidentiality was seen as imperative. In an explanation provided by the FSUG about the criticisms of the culture report, it was noted these had caused the FSUG team some distress. In consideration of over 500 contacts they had worked with in five years, the team were certain they had never breached or infringed the principle of confidentiality. In the April 2023 public trust board paper, the FSUG stressed how following concerns raised entirely within due process with management, contacts then felt exposed more so by management and subject to detriment.

In the 2022 NHS Staff Survey:

- 53% of staff said they felt safe to speak up about anything that concerned them. This was worse than the national average of 60%.
- 42% of staff said they were confident their concern would be addressed. This was worse than the national average of 47%.
- 66% of staff, the lowest number in the last five years, said they would feel secure raising concerns about unsafe clinical practice. This was worse than the national average of 71%.
- 50% of staff said they were confident the organisation would address their concern. This was the lowest result in the last five years. The national average was 56%.

Despite efforts across the trust to publicise the role of the Freedom to Speak Up team, we found staff in more junior roles were unaware of the service. Nevertheless, quite a few staff told us they had used the service and thought it was excellent and met their needs. Some who were aware of the service but had not used it said they felt the service was not secure (even though they admitted they had not experienced this failing themselves, it was a perception) or they would

prefer to talk with their manager, peers or colleagues. Those staff who had used the service said they had appreciated the support received and felt they had been heard. A number of staff said the FSUG team were doing their best in a difficult environment, and often without the support needed to effect change or learning and excessive time taken for anything to progress, if it did.

When staff in pharmacy felt pressured, they were able to raise concerns directly with their line manager and discuss how to support each other within a team. Support included weekly meetings and an approachable open-door policy by clinical operational leads which was welcomed by staff. However, some staff said it was a challenge to raise concerns directly with the senior leadership team and felt that they were not always listened to or supported. There was a forum where staff could raise concerns anonymously which staff found useful and a Freedom to Speak Up Guardian within the pharmacy team, which the staff told us needed to be promoted more.

Following our inspection the trust updated us on plans for the future and actions it was taking in response to the recognised concerns around culture. This included the development of a Culture and Inclusion Board established in October 2023. This was chaired by the CEO and accountable through a board committee to the executive board. A 'Wise Council' was being established for any staff who wanted to participate and was starting from January 2024. This was described as a 'safe space' to look forward, provide assurance and support, and be constructive. The trust had signed the NHS sexual safety charter and launched a campaign around ending sexism and sexual harassment, which included bespoke artwork.

In 2022, NHS England and the National Guardian's Office (NGO) issued revised guidance about the Freedom to Speak Up function. This included a recommendation for the trust to complete a self-assessment using the 'reflection and planning tool' to determine if the service was optimal and fit for purpose. The tool should be completed every two years and provided to the board for review. The first review and report to the board was due at the latest by January 2024 and had not, as yet, been submitted to the NGO following board review. The trust updated us following the inspection to advise the self-assessment was in progress but would not be presented to the full board until May 2024, and therefore would miss the January 2024 deadline.

Some staff at the trust were concerned about the perceived seniority of those people in the FSUG team being a possible barrier, although acknowledged the firm commitment of the FSUGs to the role. Although the trust had 12 FSUG 'Champions' all around the organisation, it also had 30 'confidential contacts' (an atypical model the trust had developed which did not follow guidance). The use of 'deputy' FSUGs was also atypical and not in accordance with the NGO guidance. However, the Guardian and the deputies had been formally trained in the role by the NGO team. The NGO guidance required all Guardians and Champions to be trained through its process and registered with the NGO. The model at the trust did not meet this guidance with the use of the extra role of confidential contacts or registering and training all staff through the approved process. The use of these extra roles could be considered confusing and less simplistic than keeping to the traditional named roles of Guardians and Champions only and following the tailored training for these roles. The trust told us the Champions were able to provide 'sign posting' for staff but not detailed support. The confidential contacts would speak with any member of staff who approached them, record details of the concerns, offer advice if appropriate, and then discuss with the Guardian. However, this use of confidential contacts and how they operate remains contrary to advice and guidance from the National Guardian's Office. Newly appointed Champions and confidential contacts had a mentor for the first year and the whole team met together quarterly.

We were told by some staff the trust did not have a FSUG or deputy who felt independent to many staff, or who had experienced their working life from a similar standpoint. We recognised how this might be significantly improved with

the implementation of the plan recommended by the FSUG team themselves to appoint Guardians on each of the four hospital sites with more localised connections in the new structure. Unlike some models used by large NHS trusts, UHB did not have a fulltime dedicated Guardian, but the trust told us the service was available to staff across seven days. However, with the size of the organisation, the workload was significant.

In October 2023, the FSUG team issued a revised statement about their role to be communicated to all staff. This explained how the service was completely confidential, but how staff might be asked if they would agree to being identified in certain understandable circumstances as some problems were difficult to resolve otherwise. It also explained the role to staff and offered the opportunity for staff to join the team. Also in October 2023, the FSUG produced an action plan in response to the culture review published the previous month. In this plan, the trust was criticised by the FSUG for the delays in dealing with some concerns. The trust senior leadership was asked to have detailed consideration of this due to the despondency and loss of confidence felt by the staff concerned. However, the FSUG team reported to us how support to them particularly by the Chief People Officer had been excellent and they were represented on the board by support from the senior independent non-executive director.

In terms of contact with the FSUG team, and allowing a national comparison with NHS data, there had been 72 contacts in the three months from January to March 2023. This was against an NHS average of 22 contacts in three months. The 72 contacts represented 3.58 cases when comparing against staff numbers of 1,000 whole-time equivalent staff. The peer average was 4.34 cases for each 1,000 staff, so the trust had a slightly lower rate of contact. However, in terms of cases relating to bullying and harassment, there were 0.99 cases per 1,000 staff in this period, which put the trust above (having more contacts than) its peer average of 0.88. At the trust, this subject matter represented 28% of cases, against a peer average of 20% and national average of 17%.

Looking back since the inception of the FSUG role in 2018, around 34% of cases had related to bullying and harassment in the past five years, a further 9% to racism-based or gender-based discrimination cases. Patient safety represented around 8% of cases. Around 31% of cases had come from doctors, the highest proportion in the staff group, although the spread was latterly more equal in the staff groups (relative to numbers of staff in these groups).

The trust was in the process of a review of the Freedom to Speak Up Guardian programme with support from the National Guardians' Office and NHS England. This included completing the self-assessment, and reviewing other speak-up programmes both in the NHS and outside to determine where these worked well and brought effective change. Staff were also being asked to give their thoughts and feedback on a future process. The new model was expected to be finalised by 1 April 2024.

There was evidence of the risk of a potential 'closed culture' developing. Our concerns come from those things described in more detail elsewhere in this section, but included risk factors such as shortages of staff, high levels of staff vacancies, high levels of staff sickness, and a high turnover of staff, all of which were present. Signs of a closed culture included:

- Staff being fearful of speaking up.
- Allegations of staff bullying.
- Allegations of failures to address issues of concern among staff.
- Poor levels of training, appraisals or support for staff to have the skills to do their work safely and effectively.

Our findings

The evidence and academic thinking around closed cultures, the signs and risk factors have been shown to link to people receiving poor care. Roger Kline, in 'Paradigm lost? Reflections on the effectiveness of NHS approaches to improving employment relations' writes: "how staff are treated impacts significantly on their health and wellbeing, on organisational effectiveness and on the care patients receive." (Kline, R BMJ Leader, 2023).

The trust had appointed a Guardian of Safe Working (GSW) in August 2018 and a deputy in September 2019 to support junior doctors. This was, as required, senior appointments and part of the new junior doctor's contract from 2016/17. Both senior doctors were independent of trust management and champions of compliance with safe working hours and safety-related exception reporting. The GSW was required to report to the trust board quarterly at least and produce a consolidated annual report. These reporting requirements were met.

In the annual report, exception reports made by junior doctors were listed but there was no analysis of trends or comparators with previous years to enable to board to see if these reports were rising or falling. The deputy GSW told us how the exception reporting was reducing as the doctors shift rotas were improved. However, the report did not provide the board with that detail. NHS England guidance around 'eight high impact actions to improve the working environment for junior doctors' was not recognised by the deputy GSW and was not referenced in the board report for assurance.

The regular GSW report was required to produce information for the board on rota gaps for all shifts, this was not provided or analysed. However, as required, the trust published data and comment on the GSW in its 2022/23 annual quality report and mentioned work being undertaken on filling rota gaps and ensuring doctors took breaks.

The Equality Act 2010 requires organisations with more than 250 employees to publish an annual gender pay gap report. This was published by the trust in the July 2023 board papers. The gender pay gap is the difference between the median or mean hourly rate of pay to male and female staff. The mean pay gap is the difference between average hourly earnings of men and women. The median pay gap is the difference between the midpoints in the ranges of hourly earnings of men and women.

Trust data on 31 March 2023 showed (against NHS averages):

- The mean gender pay gap was 26.4% (peer average 24.9%; national value 20.5%)
- The median gender pay gap was 13.5% (peer average 12.4%; national value 9.3%)
- The mean gender bonus gap was 48.3%
- The median gender bonus gap was 66.7%

These measures indicated in every measure that male staff were receiving a significantly higher proportion of pay than females. The mean average bonus gap being 48% and median 67%. The trust board was told a group had been established to address some of the issues and described some of the actions to be considered. However, there were no measures of success indicated and no strategic objectives in the organisation to work towards making a material difference to this inequality. We reviewed the strategic risk 'creating a healthy and fair place to work'. There was no mention of the gender pay gap and on searching the board assurance framework, this topic was not covered with the exception of a green (completed) action showing a report on gender pay gap had been provided to the board.

A number of senior women in the organisation spoke of their perception of the trust making it hard for women to get into senior leadership positions. Others spoke of "passive discouragement of women" and of there being no recognisable or active process to improve this perception or reality.

Our findings

Actions taken to address behaviour and performance were not always consistent with the vision and values, regardless of seniority. Some staff raised concerns with us about sexual safety. These were also raised in the work of the recent culture review. Just prior to our inspection, on 16 October 2023, the trust signed up to the NHS England Sexual Safety Charter launched in early September 2023. This charter had been developed with the intention of eradicating sexual harassment in the workplace. Alongside being signatories to the charter, the trust had further work to complete in this subject to ensure staff felt safe. We heard examples of staff feeling let down in attempting to speak up about sexual harassment, intimidation, inappropriate, or misogynistic behaviour. Staff spoke of fears for other colleagues who they felt were at risk from being afraid to speak up.

Senior executives and members of the trust board spoke of their concerns in this and all areas relating to culture, but accepted more needed to be done to provide effective advocacy and allow people to feel justified and safe in speaking up.

Although staff we spoke with were dedicated to the needs and experience of people who used services, some did not see this as the organisation's top priority. Some staff did not always feel positive and proud to work in the organisation. In the 2022 NHS Staff Survey, three indicators looked at this subject:

- 66% of staff felt care of patients was the organisation's top priority. This was worse than the national average for the peer group of NHS trusts of 74%. This response had deteriorated year on year since 2018 when at that time the trust was only just below the national average of 77%.
- 48% of staff said they would recommend their organisation as a place to work. This was worse than the national average of 57%. This response had deteriorated year on year since 2018 when the trust was much the same as the national average of 62%.
- 56% of staff said they would be happy for a relative or friend to receive treatment at the trust. This was worse than the national average of 62% and had again deteriorated year on year since 2018. For 2018, 2019 and 2020, the trust scored in line with the national average of around 70%.

Not all staff felt equality and diversity were always promoted within and beyond the organisation. Staff, including those with protected characteristics under the Equality Act, felt they were not always treated equitably. This was an organisation located in one of the most ethnically diverse parts of the country. Around 35% of trust staff were from an ethnic minority group compared with a local population of around 23%. The 2022 NHS Staff Survey and the Workforce Race Equality Standard metrics indicated a worse experience for staff from other ethnic groups when compared with White staff. These included:

- 41% of staff from ethnic minority groups (compared to a national average of 47%) believed the organisation provided equal opportunities for career progression or promotion. This was 55% for White staff (compared to a national average of 59%). This indicator had remained fairly static for the last five years.
- 16% of staff from ethnic minority groups (compared to a national average of 17%) said they had experienced discrimination from a colleague in the last 12 months. This was a percentage point higher than in 2019, although the indicator had remained fairly static. This was 8% for White staff (compared to a national average of 7%), which had slightly increased in the last five years.

The trust facilitated a number of networks to support staff in minority groups. These included:

- Lesbian, Gay, Bisexual and Transgender + staff network
- Black, Asian and minority ethnic staff network

Our findings

- Carers' staff network
- Disability or long-term health conditions network
- Faith staff network
- Women's staff network
- Men's staff network
- Neurodiversity staff network
- Mental health and wellbeing staff network

Meetings were held monthly or bi-monthly and we were told by the trust all staff were welcome and encouraged to attend including 'allies'. Allies were those staff who may not personally identify with a minority group, but believe everyone in the organisation should experience full equity. We met with staff from a number of these networks and were told of strong support to the groups from the executive sponsor and broader support across the senior leadership team.

However, although this was the clear intent of the trust, some staff told us their colleagues were too often prevented from joining meetings due to staff pressures or being told by their own management how this was not a priority. This was seen by the attendance levels reported by the network leads, which were considered by the leads as disappointingly low.

The network leads did report some excellent work undertaken in the trust particularly around disability and the 'fairness' task force. The trust was also a Stonewall Champion organisation which supported LGBTQ+ people. We were told there was still work to do on the following:

- Promoting the networks and a programme of communication which was effective.
- Enabling staff across the trust to join calls and meetings and be encouraged to take part.
- The organisation becoming 'trusted on transgender rights'.

We also noted the trust did not use the term 'ethnic minorities' when talking about ethnic minority staff but used the term 'Black, Asian and minority ethnic (BAME)' which was no longer a government preferred term (since 2021). The trust advised us, following the inspection, that the 'Black, Asian and minority ethnic staff network' (BAME) were consulting with the membership about the language and description to be used in future. Five alternative phrases to replace BAME were being voted on.

Those staff we met representing the ethnic minority network said they had excellent support from the Chief People Officer as their board sponsor and were waiting for the appointment of a non-executive director as sponsor of equality networks. They had been enabled to be part of the wider network hosted by the local integrated care system. They were proud of the work the trust had undertaken around reciprocal mentoring and 200 colleagues had been through the programme in the first year. This was not just staff from ethnic minority backgrounds, but this was an aspect of the programme among wider mentoring opportunities.

We were concerned about board assurance around actions to improve equality, diversity, and inclusion. The trust board report into the Workforce Race Equality Standard (WRES) 2022 provided an executive summary. This did not highlight for the reader areas of concern which stood out for the trust from the survey and just stated it represented a "changing

position". The executive summary then described an action plan, but with no consideration of the important findings from the survey and therefore, no documented actions to address these. However, in the detail of the report, although not clearly defined, the open and honest report highlighted some of the areas of improvement and where there was more work to be done. The trust had seen improvements in:

- A slightly reduced number of ethnic minority staff were likely to enter a formal disciplinary process than in 2021.
- More ethnic minority staff were accessing non-mandatory training and continuous professional development than White staff.
- There was a decrease in the levels of bullying and harassment from patients, relatives or members of the public on staff from an ethnic minority background. The trust reported it had made improvements in reducing the instances of this risk to staff in the last year.
- The introduction of independent panel members at interviews (who were trained experts who either identified with an underrepresented group or protected characteristics or would have demonstrated their commitment to championing equality and diversity) was starting to make an impact (although the report did not specify quite how that was being measured). However, the report further stated that "the evidence of systemic barriers across the recruitment, promotion and development processes continue to prevail, born out of inconsistent processes, hierarchical tendency, and hidden cultures at play."

Areas the report highlighted as concerns included:

- There was a lack of trust for staff from ethnic minority groups when it came to career development and promotion.
- Some senior and career development opportunities were not equally communicated, accessed or monitored for staff from ethnic minority groups.
- There were significant levels of staff from ethnic minority groups experiencing discrimination when it came to accessing senior development programmes. The trust did not further comment in the report about how it made this judgement.

The trust's most recent action plan from the WRES survey (WRES action plan 2022/23 – Update Oct 2023) showed how the team looking at equality, diversity and inclusion were not able to demonstrate the progress they had hoped for. The action plan was undated and it was, therefore, unclear when any progress had met the milestones or targets. The action plan had no clear objectives or goals to determine how success was measured beyond improvements in survey results.

Disabled staff at the trust had a worse experience than their colleagues. The lowest ranking scores in the 2022 Workforce Disability Equality Standard (WDES) were for staff engagement and staff feeling valued. In this standard, the trust was rated 181 out of 212 NHS trusts across England.

We were concerned about board assurance around disability. The executive summary to the board of the annual WDES report did not report on these negative findings but concentrated to an extent, on the number of staff declaring a disability on the electronic patient record. It was not stated, as to why this was specifically relevant over the headlines of the WDES report.

In the 2022 NHS Staff Survey, disabled staff at the trust who responded reported negative experiences in every indicator. There had been a slight improvement in some of the indicators, although less improvement in the gap between disabled staff and non-disabled staff. As with the WRES action plan, there were no measures of success provided to judge if the actions taken to reduce disparity of staff experience had made a difference.

Our findings

Since the pandemic, the trust had recognised the need to be stronger on staff wellbeing. It was understood, we were told by the wellbeing leads we met, that looking after staff helped them to better meet the needs of patients. Certain arrangements were made, such as food parcels (culturally specific) food banks, clothes or school uniform swops, psychological first aid, financial support, and support for staff being made homeless due to hardship. Since the current cost of living crisis emerged, around 40 staff at the trust found themselves homeless. The wellbeing manager had been enabled to make arrangements to ensure no member of staff was left with nowhere to sleep. We recognised this as outstanding practice.

Despite the success, dedication and commitment of the wellbeing team, they raised concerns with us about insufficient or ineffective support in promoting and advertising the services around wellbeing, including the offer of occupational and mental health professionals. Despite executive support for the wellbeing service, there was less support around promoting the service so all staff knew about it. We asked a number of staff we met if they knew of the service and some staff knew some things they had been told about, but there was no comprehensive recognition.

Governance

There were improvements and transformation programmes for governance which were underway as the organisation moved away from divisions and corporate oversight to mostly hospital-based structures. The trust was responding to criticism and making changes to its structure and said to be strengthening the governance and oversight of the trust. These changes were as yet untested at the time of our inspection, but were much-needed to be able to govern the organisation effectively and have a shared and more localised bespoke responsibility for quality and safety.

Leaders and teams mostly used data to manage governance effectively, but there were some notable gaps in board assurance. This included learning from when things went wrong and measuring success effectively. The trust had work to do to comply fully with the regulations around Fit and Proper Persons and having effective assurance.

There was a varied response from staff about the new structure, although most felt it was a positive move for the organisation and most were looking forward to settling into the new ways of working. However, some staff felt the new arrangements had been rushed through and there was still a lot of uncertainty. Some said they no longer knew who to ask about governance, such as audits, reporting lines and various meetings which had been standard up until the changeover in October 2023.

A number of staff reported on the positive interactions already with the new management in the hospital sites and feeling more connected. There were concerns though from those teams who remained ‘corporate’ and some feeling they did not know how they fitted into the new arrangements as yet. However, staff agreed it was ‘early days’ and they needed to give the new arrangements chance to settle.

The previous governance structure of this organisation gave rise to concern around the capacity of the trust executive team to manage such a large organisation effectively and understand areas of existing and emerging concern and risk. The new arrangements to transform the trust from a divisional arrangement to mostly site-based services and governance had been designed to address this risk. It was too early in the process to evaluate the performance of the new structure and we will revisit this when it has been given chance to embed effectively.

Our findings

There were a number of valuable key measures of performance or evidence of when things went wrong not used or not reported for assurance of change. They were mostly reported in numerical or volume data and with little if any, narrative around learning or improvement. This meant board oversight of poorly performing services was unclear. These included:

1. **Serious incidents and Duty of candour**

The trust reported data on serious incidents to the board, which included 'never events' (Never events are serious, largely preventable patient safety incidents that should not occur if healthcare providers have implemented existing national guidance or safety recommendations), infection prevention and control, pressure ulcers and falls. There was no assurance to the board of learning or improvement. These reports focused on data and some description of the incident, but no information on any themes, or whether learning was needed to reduce patient harm from these events. Any themes reported were general requirements for risk assessments, but without ownership of actions needing to be taken, or how they would be measured.

In further detail of patients suffering pressure ulcers and falls causing severe harm, classed as serious incidents, the trust board were provided with statistics reporting how many had happened. There was some commentary provided about pressure ulcers and how they had occurred, but no evidence to show how learning and improvement would happen. In terms of falls with severe harm, the trust integrated performance reports listed the events which led to the falls and some information around themes. However, there was no evidence to provide assurance to the trust board that learning and improvement was happening for the safety of patients, particularly as the number of falls with severe harm was reported as increasing. For example, there were 2 falls with harm reported in August 2022 and 11 in August 2023, with 2 described as "catastrophic" with the patients sustaining subdural haemorrhages.

Alongside the lack of evidence to the board to show how serious incidents were being learned from was the lengthy amount of time taken to investigate and publish reports. In 11 serious incident investigation reports we reviewed, the average time taken was 9 months. The longest was 16 months and the shortest 2 months. One of these investigations was from an incident in 2020 but the incident was only commissioned for investigation in October 2022 following a complaint from the patient's family. This investigation took 10 months to complete. The trust had recognised the delays to some of these reports was not meeting its objectives to respond to patients and families far quicker. It had obtained additional funding to employ another investigator to join the team to help with the backlog of incident report investigations, a lot of which had built up as a result of the COVID-19 pandemic.

We were concerned with some of the investigations as to whether the legal requirement to fulfil the duty of candour were met. Duty of candour comes into force when an incident is that described in law as a "notifiable safety incident" which has led to death or severe, moderate or prolonged psychological harm. The legal duty requires the trust to provide an honest and factual account of the incident to the relevant person. A written notification should follow which includes an apology and an explanation of what further enquiries are going to be made.

In the 11 investigation reports we reviewed, the trust did not describe in the "Duty of candour/being open" section if the notifiable safety incident threshold had been reached. The report described some steps taken by the staff involved, but it was not clear if these met the duty of candour objectives. As the trust board were given no assurance through performance reports around duty of candour principles being adhered to, these reports were a source of that assurance. However, following our inspection, the trust provided us with evidence of fulfilling its statutory obligations to be open, honest and apologise to patients or those who represented them. Nevertheless, the section in the investigation reports entitled "Duty of candour/being open" did not provide assurance to stakeholders of the duty being met, and did not respond to the intention presumed by the title of the section.

Our findings

Five of the reports we reviewed demonstrated the duty being met. Five others did not provide assurance of duty of candour being carried out and one was ambiguous. One specific report had an exceptional delay of seven months following the death of a patient before the patient's family were contacted and no explanation for the delay was provided.

In one of the investigation reports, where there was an error in medicine administration which caused cardiac arrest, this was not reported as being explained to the family. In another investigation, described as a catastrophic incident, and an avoidable death, there was no investigation into failings until the trust received a letter from the patient's family two years after the patient's death.

The Parliamentary and Health Service Ombudsman (PHSO) criticised the trust in August 2022 and an investigation led it to report how concerns it had were "heightened by:

- The defensive approach when discussing patient safety issues with us
- UHB's failure to fully accept or acknowledge the impact of our findings from investigations, including an avoidable death
- UHB's approach towards duty of care to its staff."

Since the criticisms were raised by the PHSO, the trust told us it had been working with the department. We were advised how the trust and PHSO worked together on training for staff, senior executives were charged with signing off action plans developed from any upheld complaints made to the PHSO. A further review by the PHSO would be undertaken in February 2024.

2. **Learning from death**

The trust's integrated quality report (covering performance, safety and quality) opened with a section on 'learning from death'. This report covered data around mortality indicators and statistical outliers, but made no reference to learning from avoidable deaths. The board therefore, had no assurance of learning, despite the obvious title of the paper. In the quarterly report to the board we located from January 2023, there was a list of learning but no assurance of how learning or improvement would be measured for effective change. Furthermore, none of the learning from death reports met the requirements of the NHS National Quality Board learning from death guidance (March 2017 – produced in response to the events in Mid Staffordshire) in relation to demonstrating clear learning and confirming involvement of those close to the patient.

3. **Learning from complaints and concerns**

The trust's integrated quality report contained a section on complaints. This was a report describing the volume of complaints (described in a section called 'patient relations') and how many had been received, responded to and in what time period. The section reporting on contacts with the Patient Advice and Liaison Service (PALS) even reported how long it took to answer the phone, which was a negligible amount of time. There was a small section describing the themes of complaints and to which division they pertained and a large number of graphs on backlogs.

There was no assurance in this report about learning from complaints having been taken and leading to improvements. This valued resource from patients and others was highlighted only in terms of quantitative data and qualitative analysis was minimal. There was no evidence of the board receiving assurance of lessons learned. This was not least due to the evidence showing complaints had increased considerably in the last year. For example, there had been 61 complaints in April 2023, and in August 2023,194. The trust had received a high number of compliments and unlike complaints, these were reported in more detail for the board.

Our findings

4. **Legal claims**

There had been a fluctuation but overall rise in the year from September 2022 to August 2023 in legal claims against the trust. One of the categories of claims had risen from 20 claims in September 2022 to 50 in August 2023. The trust reported “no specific areas to cause concern”, which did not provide assurance to the board around this steady rising trend.

Medicine optimisation was integrated into the trust governance structure. There was a structure for the safe use of medicines with no gaps in reporting lines between committees. Committees such as the non-medical prescribing group and the medical gases group directly linked into the safe medicine practice group (SMPG) which was a multidisciplinary team. The SMPG reported to the clinical quality monitoring group (CQMG). The Chief Pharmacist attended the CQMG every quarter to present reviews of medicine incidents and highlight any trends. The Chief Pharmacist also had direct links to the executive board as they were accountable to the Chief Medical Officer.

The Chief Pharmacist and senior pharmacy leaders received incident reports to ensure they had oversight and visibility of any serious incidents and to monitor trends. This included reviewing safe handling of medicines audits. The medicine safety committee ensured medicine safety had a clear remit and was effective in monitoring and improving the quality of incident reporting, investigation and sharing of learning. Following a recent serious medicine incident, several changes were made to systems and procedures which included training of pharmacy staff to prevent the incident happening again.

The trust board had been informed about the changes to the Fit and Proper Persons Test for board members from 2 August 2023 (NHS England). The trust had recognised there was work to do to meet this commitment. An action plan had been drafted and work was in progress to achieve compliance. Following our inspection the trust provided us with a statement to the November 2023 board meeting stating the trust was compliant for the year 2022/23. During our inspection, our sample review of six files of the executive team only provided one with the record of a valid Disclosure and Barring Service (DBS) check on file. This part of the FPPR had not changed and was not a new update and all these checks should have been made and recorded in accordance with trust policy.

Following our inspection, the trust sent a statement advising these areas would be addressed in the coming weeks and reported to the board in the November 2023 meeting. This included recognition of this being the responsibility of the trust Chair to provide assurance to the board.

We were concerned the trust policy would not consider all directors to be subject to a DBS check. This was given their possible contact with patients as part of their visits to ward and departments. The trust policy gave rise to doubt this would be the case for all directors and not all might be subject to the highest level of check. The CQC Fit and Proper Person Regulation 5(3)(e) states “a person who will be acting in a role that falls within the definition of a “regulated activity” as defined by the Safeguarding Vulnerable Groups Act 2006 must be subject to a check by the Disclosure and Barring Service.” The trust did not specifically outline within its local policy the relevant DBS check required for each individual board member, as required by NHS England, and leaving room for ambiguity.

Management of risk, issues and performance

Leaders and teams mostly used systems and data to manage performance effectively, but there were some notable gaps in board assurance. This included learning from when things went wrong; certain performance indicators; and metrics to show staff were well supported and given the right and timely training. Performance indicators in some key areas were showing strong improvement, but not in others, some of which were not being reported to the board directly.

Our findings

The trust was at risk from a significant financial deficit which represented 95% of that incurred by the local integrated care system. The issues raised with us around culture suggested there was a significant risk of the people function (also known as human resources) being either overwhelmed or was at risk of being so. We were uncertain the trust had accurately rated its risks given the current culture problems and how they affected wellbeing, patient care and employment metrics.

The trust's current board assurance framework (BAF) was extensive and detailed. The September 2023 BAF presentation to the board with its covering paper ran to 60 pages. It was difficult to get strategic assurance from the current document which acted more as a corporate risk register. On the strategic risk register were 12 objectives with each having a risk descriptor. We were concerned given the culture reports in 2023 how this was not rated with some of the highest indicators. The current risk was rated on a 5x5 RAG rating as 12 (3x4) with no clarity as to how the risk had been reduced from its initial rating of 16 (4x4). Other risks relating to culture were: Building the workforce of the future, rated 12 and, Developing, valuing and supporting our people at all levels as leaders and enablers, rated 6.

The Chief Finance Officer told us how finance was one of the highest risks for the trust. This was based on the trust being at the time of our report 95% of the integrated care system deficit (see below for the section on finance) and the requirement for a revised forecast.

We were told the current BAF was being revised in line with the new governance arrangements and a draft proposal would be made to the board in November 2023.

The pharmacy department had its own risk register as did and each area within a speciality. The risk register was reviewed monthly, and all high-risk areas were elevated to the trust board.

The main risk for the medicine optimisation service was the lack of capacity and vacancies within the pharmacy team to cover every specialist area of the trust. Due to the gaps in the pharmacy service, there was an increased risk of reducing clinical screening in areas with no pharmacist input. This was mitigated by ensuring high risk areas had a clinical pharmacy visit. There was also an impact to the provision of aseptic manufacturing services due to the ongoing staffing issues. Some aseptic manufacturing was being outsourced. The manufacturing aseptic team were working hard to ensure patients received their treatments, but it was recognised there was pressure on the team.

The performance at the trust had been in the same challenged place as all NHS trusts in England coming out of the pandemic and managing staff shortages, strikes, and growing demand on capacity. The trust was making good progress in dealing with some of the key performance areas, such as bringing down some waiting times and reducing patients who did not attend appointments. Even though they did not meet national targets, progress could be seen. Along with data on 18-week waiting lists and 12-hour trolley waits, there were a number of areas where the board were not being provided with assurance on support for staff, or their evaluated experience, skills and competence (appraisals). Staff training compliance was not discussed at board.

There was insufficient assurance provided to the board about staff performance reviews or compliance with training and development. This was a requirement for board assurance of a supported workforce who had the experience, skills and qualifications to treat and care safely for patients and give quality care. Despite reviews of trust documents, we were unable to locate data on overarching training compliance, mandatory or otherwise, or appraisal compliance. This was not in the annual reports on workforce or people. Sickness absence was reported, but despite the rate of sickness being around 2.5% above the trust target of 4% in the year July 2022 to June 2023 (although on a downward trend), there were

no actions reported to the board to provide assurance of actions to reduce sickness. The reasons for the most absence were psychological issues (26%) followed by musculoskeletal (11%) although the trust did not indicate if it had data on whether these were work-related problems. Long-term absence was around 3.5% on average, but, as with short-term absence, this had been reducing in the year.

Following the inspection, the trust explained how this information on a competent and supported workforce was discussed in detail by the trust board committees, specifically the people and culture committee. However, it was not discussed in the People Report to the board (January 2023), and in no subsequent document. The trust board was therefore not given assurance of a competent, trained and supported workforce. Nevertheless, it was noted from the committee reports that for October 2023, mandatory training was meeting and exceeding trust targets (actual 93% against 90% target), but appraisals were falling behind (actual 75% against 90% target). This information was not presented to the board and therefore not published by the trust on its public website.

The data we were provided in board reports in relation to vacancies was limited and in the July 2023 board papers, the vacancy rate was provided but with no detail, longer-team trend analysis or any notable achievements to provide the board with assurance.

The annual workforce report to the board for 2022/23 was presented in July 2023. One area of success was reported as the time to recruit and the report said there had been a big reduction in “time to clear”. This was the time the trust took to undertake employment checks before a new member of staff started work. This had reduced by 6 days in the July 2023 board report from the previous year. The “time to hire” had also reduced (improved) to 13 days on average which was well below the target of 21 days. However, a few staff we met, particularly in administrative posts, felt this was not always true for them or their area of work. They still felt the time gaps were excessive and were critical of the pressure this caused them in filling vacancies efficiently.

The trust board had been informed by the Chief Medical Officer that a quarter of doctors had not had an annual appraisal in the year 2022/23 (a requirement of their revalidation). There was no explanation offered why these 546 doctors had not been through this review of their performance or any requirement for support. The 76% compliance rate failed to meet the trust standard of 90%. An action was said to have been raised from the previous year to increase the number of appraisals in 2022/23. This was despite appraisals being paused in 2021/22, 2020/21 and 2019/20 due to the pandemic and there being consequently no report in those years of appraisals. However, the report said this increase had not been achieved and the rate had dropped. This was despite most doctors not having an appraisal for three years. The action this year was to “continue to improve annual appraisal rates”, and the trust had sufficient trained appraisers to carry out these reviews.

Some of the administration and clerical staff we met were concerned about the trust's position on recruitment and probationary contracts for new staff. They were concerned new staff were not subject to a probationary period and some recruited and starting without references. The trust had intentionally removed the probationary period for new starters around 10 years ago and trusted the recruitment process and any additional support to new staff to be effective. This was revisited in 2022 and reintroduction of probation periods proposed. However, this was not brought back at that time, not least due to the perceived pressure on line managers to add this duty to their tasks.

The trust advised that any staff offered contracts who were then given unsatisfactory or no references would have that employment withdrawn – and this had been the case in 36 offers in the last 12 months. It was therefore concluded some

of the staff we met were unaware of the trust's position in relation to probation periods and references and the history behind the decision. The trust told us it would revisit this again, but we noted there had been very few cases over the past couple of years where staff employed for less than six months had been put through any form of performance management.

The trust had a significant financial deficit against planned income and expenditure. At the end of month five (August 2023) of the financial year, the trust deficit was £39.4 million, which was 95% of the integrated care system deficit and a £30 million variance against plan. The trust's finance plan at the start of the financial year was to break even. The main driver of the deficit was in expenditure on pay which was over £50 million extra against plan. These was made up from:

- Extra £5 million to substantive staff.
- Unplanned 14% additional pay for bank staff.
- £1.1 million over the cap on agency staff spend.
- Savings or extra revenue had been seen on healthcare income and income for high-cost drugs.
- There had been a small favourable variance in cost improvement savings, although this showed a deficit when non-recoverable amounts were removed.
- The trust was showing a deficit against planned elective activity of £10.6 million. This was partly due to industrial action.

The trust board were advised that the finance team was preparing a financial recovery plan to present to the integrated care board. The financial recovery plan was presented to the trust board in September 2023 in the private sessions. This laid out the equality and quality impact assessments required for each initiative, to support the intention for there to be no unintended impacts upon patient safety and the quality of care.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔➔ Mar 2024	Good ➔➔ Mar 2024	Good ➔➔ Mar 2024	Requires Improvement ➔➔ Mar 2024	Inadequate ↓↓ Mar 2024	Requires Improvement ➔➔ Mar 2024

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Queen Elizabeth Hospital Birmingham	Requires Improvement →← Mar 2024	Good →← Mar 2024	Good →← Mar 2024	Requires Improvement →← Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement →← Mar 2024
Birmingham Heartlands Hospital	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Good Hope Hospital	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Solihull Hospital	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Overall trust	Requires Improvement →← Mar 2024	Good →← Mar 2024	Good →← Mar 2024	Requires Improvement →← Mar 2024	Inadequate ↓↓ Mar 2024	Requires Improvement →← Mar 2024

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Queen Elizabeth Hospital Birmingham

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires improvement Feb 2021	Good Feb 2019	Good Feb 2019	Outstanding Feb 2019	Good Feb 2019	Good Feb 2019
Critical care	Requires Improvement ↓ Mar 2024	Outstanding →← Mar 2024	Outstanding May 2015	Outstanding May 2015	Requires Improvement ↓↓ Mar 2024	Requires Improvement ↓↓ Mar 2024
End of life care	Good May 2015	Good May 2015	Good May 2015	Outstanding May 2015	Good May 2015	Good May 2015
Outpatients (sexual health services)	Good May 2015	Good May 2015	Good May 2015	Good May 2015	Good May 2015	Good May 2015
Surgery	Requires improvement Oct 2021	Good Oct 2021	Good Feb 2019	Good Feb 2019	Good Oct 2021	Good Oct 2021
Urgent and emergency services	Inadequate Feb 2024	Requires improvement Feb 2024	Good Feb 2024	Requires improvement Feb 2024	Requires improvement Feb 2024	Requires improvement Feb 2024
Outpatients	Good Feb 2019	Not rated	Good Feb 2019	Requires improvement Feb 2019	Good Feb 2019	Good Feb 2019
Cancer services	Requires improvement Feb 2024	Good Oct 2021	Good Oct 2021	Requires improvement Oct 2021	Requires improvement Feb 2024	Requires improvement Feb 2024
Neurosurgery	Requires improvement Feb 2024	Requires improvement Feb 2024	Good Feb 2024	Requires improvement Feb 2024	Inadequate Feb 2024	Requires improvement Feb 2024
Overall	Requires Improvement →← Mar 2024	Good →← Mar 2024	Good →← Mar 2024	Requires Improvement →← Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement →← Mar 2024

Rating for Birmingham Heartlands Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires improvement Apr 2023	Requires improvement Feb 2019	Good Feb 2019	Good Feb 2019	Requires improvement Apr 2023	Requires improvement Feb 2019
Maternity	Inadequate Feb 2024	Good Feb 2019	Good Feb 2024	Good Feb 2019	Inadequate Feb 2024	Inadequate Feb 2024
Surgery	Requires improvement Feb 2019	Good Feb 2019	Good Feb 2019	Requires improvement Feb 2019	Good Feb 2019	Requires improvement Feb 2019
Urgent and emergency services	Inadequate Feb 2024	Requires improvement Feb 2024	Good Feb 2024	Requires improvement Feb 2024	Requires improvement Feb 2024	Requires improvement Feb 2024
Overall	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated

Rating for Good Hope Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Inadequate Feb 2024	Requires improvement Apr 2023	Good Feb 2024	Requires improvement Apr 2023	Inadequate Feb 2024	Inadequate Feb 2024
Maternity	Requires improvement Jun 2023	Good Feb 2019	Good Feb 2019	Good Feb 2019	Inadequate Jun 2023	Requires improvement Jun 2023
Surgery	Requires improvement Feb 2019	Good Feb 2019	Good Feb 2019	Requires improvement Feb 2019	Good Feb 2019	Requires improvement Feb 2019
Urgent and emergency services	Inadequate Feb 2024	Requires improvement Feb 2024	Requires improvement Feb 2024	Requires improvement Feb 2024	Inadequate Feb 2024	Inadequate Feb 2024
Overall	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated

Rating for Solihull Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires improvement Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019
Maternity	Good Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019	Requires improvement Feb 2019	Good Feb 2019
Surgery	Requires improvement Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019
Overall	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for children and young people	Requires improvement Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019	Requires improvement Feb 2019	Requires improvement Feb 2019
Community end of life care	Good Feb 2019	Requires improvement Feb 2019	Good Feb 2019	Good Feb 2019	Requires improvement Feb 2019	Requires improvement Feb 2019

Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Queen Elizabeth Hospital Birmingham

Mindelsohn Way
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Description of this hospital

The Queen Elizabeth Hospital Birmingham (QEHB) is part of the University Hospitals Birmingham NHS Foundation Trust which is one of the largest teaching hospital trusts in England, serving a regional, national, and international population. The hospital is a 1,215 bed, tertiary NHS and military hospital in the Edgbaston area of Birmingham, situated close to the University of Birmingham. The hospital provides a range of services. The hospital has the largest solid organ transplantation programme in Europe. It has the largest renal transplant programme in the United Kingdom, and is a national specialist centre for liver, heart, and lung transplantation, as well as cancer studies. It is also a regional centre for trauma and burns.

Critical care

Requires Improvement ↓↓

Is the service safe?

Requires Improvement ↓

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

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and mostly kept up-to-date with their mandatory training. Information received after the inspection showed 94.7% of staff had completed mandatory training within the service. This was above the trust target of 90%. However, there were some modules which were below the 90% trust target, this included conflict resolution which had an 88% compliance, fire safety which had an 86.7% compliance, health safety and welfare which had an 86.2% compliance and information governance which had an 88.4% compliance.

The mandatory training subject areas was not comprehensive and did not meet the needs of patients and staff. Training on sepsis, recognising and responding to patients with mental health needs, learning disabilities, autism and dementia was not included within the mandatory training for staff. However, although not mandatory, training was offered. For example, staff had access to both electronic learning and classroom training sessions for sepsis. Information received after the inspection showed 210 staff had completed the electronic leaning module and a total of 34 staff members had completed classroom training which included sepsis. The information did not differentiate between staff roles and did not provide a total number of staff who required this training due to this not being mandatory.

The trust provided staff with training to enhance their management of patients with mental health needs, learning disability and autism and dementia, however this was not compulsory for staff to complete. The trust had introduced and were promoting the Oliver McGowan training. Oliver McGowan training includes training in relation to learning disabilities and autism and became a legal requirement in July 2022. At the time of our inspection, only 4.6% of staff within the critical care areas had completed this training.

Staff told us there had been an increase in the number of patients who were admitted to critical care with mental health needs and they required more knowledge and support to provide care and treatment for these patients. A training package had recently been introduced and was also being promoted for staff to complete. At the time of our inspection, only 2.8% of all staff had completed this training. Additional information provided after the inspection indicated the service did not have data to show there had been an increase with patients being admitted with mental health needs. However, in addition to the specific training identified above, mental health training was also covered in safeguarding as well.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers told us staff were supported to complete their mandatory training by ensuring time was ring fenced. However, staff told us they usually had to complete the majority of their training at home. Some staff told us they would be given time back if they completed this in their own time. Staff told us training was a blend of electronic learning and taught learning opportunities. The service had their own dedicated clinical education team (with a ratio of 1 educator to 50 staff which was above the recommended ratio of 1 educator to 75 staff) who would support staff with their training needs.

Critical care

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Staff were required to complete safeguarding adults and children training (level 1 and 3) 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 91.2% and 98%. However, the information identified that critical care area B were below the trust's target of 90% with a compliance rate of 86.2%.

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 make a safeguarding referral and who to inform if they had concerns. Staff spoke confidently about safeguarding referrals and the action they would take if they had concerns. Within one area of the service, staff discussed an example of a safeguarding referral that had been made in relation to female genital mutilation and potential for further concerns.

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 had merged with the vulnerabilities team at the start of the year. Staff told us they were approachable and knew how to contact them if they had concerns about a patient.

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

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. However, they did not always keep equipment and premises visibly clean and free from clutter.

Not all areas within critical care were visibly clean despite cleaning records demonstrating that areas were cleaned regularly. We found areas and equipment with dust present, despite signs suggesting these were clean. Floors were found to be stained and appeared visibly dirty within critical care area C. We found all areas were cluttered which could impact on the thoroughness of the cleaning of the department. Within an empty side room which was ready to take a patient, we found a used vomit bowl which raised concerns over the standard of cleanliness within the unit.

The service did not always perform well for cleanliness. The critical care areas were considered the highest risk due to the acuity of the patients admitted and therefore required high standards of cleanliness. Audit information showed critical care area D had achieved the required standard for June and July 2023. However, areas A, B and C were not consistently achieving their required standard of 98% compliance with cleanliness. In addition to the cleaning audits, unit managers completed their own 'IPC walk arounds' (Infection prevention and control) using a standardised audit tool. Information shared after the inspection showed the compliance ranged between 89% to 98%. Common areas of concerns raised were in relation to high and low level surfaces which were dirty and dusty, floors still showing evidence of dirt and debris present especially in the corners, equipment being used which appeared visibly dirty and temporary closure mechanisms not being used.

Critical care

We observed staff demonstrating good hand hygiene measures in accordance with the World Health Organisations (WHO) five moments for hand hygiene. The service completed regular hand hygiene audits which showed all areas were achieving 99% compliance. We observed signs which indicated hand hygiene sinks were only for handwashing only which supported good IPC practices and reducing the risk of transmission of microorganisms.

Staff followed infection control principles including the use of personal protective equipment (PPE). There was an appropriate amount and selection of PPE for staff to use. All bed spaces had a supply of gloves and aprons for staff to use. The unit also had supplies of protective masks for use with infections such as influenza or tuberculosis. Staff were required to be fit tested for certain types of masks (FFP3 masks) however the information showed only 40.3% of staff were currently in date. The service had mitigated this risk to staff by purchasing 40 respiratory hood systems. The service also had goggles for staff to wear if there was a risk from splashes from bodily fluids.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed staff cleaning equipment after it had been used. We also saw the 'I am clean' system in place for items of equipment which had been cleaned after its use and was ready to reuse again. However, we found some items were no longer clean and had dust and debris on them.

All areas had side rooms available with anterooms which was in line with the health building note recommendations. However, information received identified the demand for single rooms meant patients requiring isolation were not always able to be accommodated, resulting in some potentially infectious patients being nursed in open areas. Where demand for side rooms exceeds the number of side rooms available, members of the trust's infection prevention and control team support staff to risk assess patients and decide who can be safely cared for in the open environment. On the day of our inspection, we were not aware of any concerns in relation to patients requiring isolation not being provided this.

We observed staff mainly using aseptic non-touch technique (ANTT) when accessing central venous catheters (CVCs), arterial lines, intubation tubes and urinary catheters to name a few common tasks. Staff told us, by ensuring they completed strict ANTT when accessing lines and catheters, this contributed to low numbers of line and catheter associated infections. However, we saw a member of staff who went to complete an aseptic procedure who did not adhere to ANTT. We raised this locally as a concern with the nurse in charge.

The service completed high impact intervention (HII) on key practices to ensure staff performed them consistently and correctly. Practices audited included insertion and ongoing care of central venous access devices, insertion and ongoing care of peripheral vascular devices, promotion of antimicrobial stewardship and prevention of catheter associated urinary tract infections. Critical care area A recorded 100% compliance with all audits between June and August 2023. Areas B, C and D all identified challenges with various practices, with area C recording only 45% compliance with the audit of insertion of central venous access devices in July 2023. Area B recorded 67.5% compliance with the audit which looked at the insertion of a urinary catheter in July 2023. This meant there had been a risk of exposure to harm from infection for patients who had these procedures performed on areas B and C. Compliance for the rest of the practices between June and August 2023 ranged from 80% to 100%.

Information received after the inspection showed between June and August 2023, there had been 0 MRSA bacteraemia's, 1 MSSA (Meticillin sensitive Staphylococcus aureus) bacteraemia's, 3 Escherichia coli bacteraemia's and 4 Clostridioides difficile (C. difficile) infections within the service at this location. All infections were taken seriously, and reviews took place to ensure any opportunities for learning were implemented.

Critical care

During our inspection, staff in critical care area A told us about an outbreak of carbapenamase producing Enterobacteriaceae (CPE). The investigation had identified 5 cases which were attributable to critical care area A, with a further 3 cases being attributed to both critical care area A and also 1 of the liver wards. As a result of the outbreak, measures were put in place which included enhanced cleaning and a new cleaning process for mattresses. There was also enhanced screening for CPE. At the time of the inspection, the root cause analysis (RCA) for the outbreak was still to be finalised. This was attributed to the complex nature of the outbreak as it involved multiple areas. This meant there had been no identification of how the outbreak occurred and therefore minimal learning in how to prevent future outbreaks from an organism which was considered a serious threat to public health and medical pathways due to the resistant nature of the organism.

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 responded quickly when called. Patients deemed to be level two (extubated and conscious) all had access to their call bells and staff responded quickly to those who required assistance.

The design of the environment followed national guidance. The critical care unit had up to 100 beds available and was flexible to the level of dependency required, however they were currently funded for 67 level 3 patients (ventilated patients). The unit was split into 4 areas each with a speciality to focus on and varying numbers of beds. The unit was located in close proximity to imaging services, main theatres and the emergency department, as recommended in Health Building Note 04-02. All bed spaces were spacious and enabled staff access to the patient from all angles as well as being big enough to accommodate any additional equipment required. However, the unit had significant storage issues which meant there was clutter within all 4 areas with some bed spaces closed to enable them to store items of equipment. At the time of our inspection, this did not impact service delivery.

Staff did not always carry out daily safety checks of specialist equipment. On critical care area A we found equipment for testing blood glucose which was part of the resuscitation trolley checks were regularly missed. On 1 of the trolleys, we found the equipment had been missed 16 days in June 2023, 7 days in July 2023 and 5 days in August up until the point of our inspection. The other blood glucose machine on the trolley near the main nurses station also had a significant number of checks missing. There were 12 days missed in June 2023, 3 days in July 2023 and 3 days in August up until the point of our inspection. We also found some additional equipment in area C which had not been thoroughly checked. We were unable to locate any other documents which identified the ‘hypo stop box’ had been checked daily (boxes to manage patients who have hypoglycaemia). The records we reviewed showed the equipment was last checked on 3 February 2023. Within this box we found some of the contents were out of date including glucose fluids and glucose tablets.

The service had suitable facilities to meet the needs of patients’ families. There were private rooms located across the critical care unit where relatives were able to hold private conversations with staff members. In addition to this there were waiting areas for families to sit with vending machines for them to use.

The service had enough suitable equipment to help them to safely care for patients. Staff told us all critical care areas were suitably equipped to care for patients. Staff stored adequate amounts of equipment to meet patients’ needs on the unit, which prevented any potential delays in admitting new patients due to insufficient equipment available. If

additional or alternative equipment was required, there was a process in place to request this. Within area A, staff told us they regularly had to request mattresses in preparation for new patients due to a long-standing management plan in place following an outbreak. Staff had no concerns over this process in terms of meeting patient need, however this meant there was a build-up of mattresses waiting to be collected and taken to be decontaminated.

Staff disposed of clinical waste safely. The management and disposal of sharps and waste was mostly completed in accordance with the trust policy. We observed staff correctly segregating clinical and domestic waste. Waste bins were enclosed and foot operated. However, we found sharps bins were not always correctly assembled due to missing information about who assembled this. The temporary closure mechanism was not always in use, however the sharps bins we reviewed were below the fill line.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient in a timely manner which removed or minimised risks. However, 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 hospital used the National Early Warning Score 2 (NEWS2) for the detection and response of deteriorating patients. We reviewed 6 records for patients admitted to all areas 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. Staff told us if they had concerns about patients deteriorating, there were always senior nursing staff or medical staff to escalate any concerns to.

Patient monitoring consisted of clinical observations (pulse, blood pressure, respirations and oxygen saturations) and continuous electrocardiogram (ECG) monitoring was also performed. In addition to this, patients who were ventilated would have regular ventilation monitoring (usually performed on an hourly basis). Depending on the patients' condition, some patients had continuous central venous pressure monitoring in addition. All information was recorded on specific critical care charts which was on the electronic system used across the trust. Staff were also able to set alarms on the monitoring machines which were specific to the patients' condition to indicate if there were any concerns. If staff identified any concerns, they responded immediately and informed the medical team.

Staff did not always complete risk assessments for each patient in a timely manner. All risk assessments were completed on the electronic system, this had an alert built which identified when assessments were required. During our inspection, we did not observe any concerns with overdue assessments. However, clinical dashboard information showed all areas had challenges in completing falls risk assessments, malnutrition assessments and skin integrity assessments. In August 2023, all areas were not compliant with completing malnutrition risk assessments within 6 hours of admission. This is a significant risk due to the severity of illness and injury in patients who were admitted to critical care and the impact nutrition has on recovery. Information showed malnutrition risk assessments were a frequent area where staff performed poorly. Falls risk assessments were another area of concern, especially in critical care areas A and D. Areas B and C had shown some improvement with falls risk assessments between June and August 2023.

Staff knew about and dealt with any specific risk issues. However, information provided did not always support that staff managed specific risks appropriately. During our inspection, we did not review any records belonging to patients who were being reviewed for sepsis. Elements of the 'sepsis 6' bundle were included as part of other audits and outcomes of

patients who were confirmed with sepsis were included within the Intensive Care National audit and Research Centre (ICNARC) data. An audit which reviewed timeliness of blood cultures was conducted in March 2022, identified some improvements were required in completing and documenting completion of blood cultures. Four patients out of 72 where blood cultures had been requested, did not have any blood cultures completed.

In a different audit, which looked at the timeliness of antimicrobial administration for patients where there were infection concerns, there were 25 patients (87 antimicrobial courses) started in critical care. Seventy-two of these were antimicrobial prescriptions relating to sepsis/infection. The audit found patients received their antimicrobials (all antibiotics) in an average time of 43 minutes. However, there were 19 courses of antibiotics which were given over 1 hour. The audit identified the trust standard for antimicrobials to be administered was within 3 hours of being prescribed, of which all antibiotics were given within 3 hours. The results of the audit raised concerns in relation to how the service were gaining assurance around antibiotic administration for patients who had sepsis, as this was not in line with recommended sepsis management. We were not assured patients consistently received antimicrobials within the recommended time frame.

The ICNARC data for patients who were admitted into critical care with sepsis showed they had a similar mortality rate to those in other trusts. This information only captured patients who were within the first 24 hours of admission. No additional information on the outcomes of patients who developed sepsis after this time was provided.

All patients received a risk assessment for venous thromboembolism (VTE) on admission to critical care. Due to their significant illnesses, most patients were deemed as high risk and therefore had mitigating actions taken such as injections to prevent blood clots and boots to maintain circulation. During our inspection we did not identify any concerns relating to patients not being assessed for VTE or receiving any preventative measures. However, information received after the inspection showed patients were not always receiving injections to prevent clots. Critical care area A had the highest rate of missed doses in August 2023 of 5.9%. This had reduced from July where 6.3% was recorded. Critical care areas B and D both indicated an increased number of missed doses in August 2023, recording 5.2% and 5.1% respectively. A review of all missed doses identified staff were indicating why doses were not provided which included medication was contraindicated and the patient had declined. The information provided did not indicate how many occasions there was no reason for the missed medication recorded.

The service had 24-hour access to mental health liaison and specialist mental health support and arranged for patients to have risk assessments completed. However, staff were concerned about the risks associated with managing an increase in patients with mental ill health whilst caring for the extremely sick and unwell patients. Staff told us about the increase in the number of patients who were admitted with mental health concerns, or their mental ill health provided a challenge once their physical health was resolving. Staff were aware of the psychiatric liaison team and the input they were able to provide. However, the ongoing challenges whilst admitted within critical care and the impact this had on safety was an area of concern for staff. Constant support from staff with a mental health background was not always something which could be provided. Staff felt vulnerable and believed there was an impact on responding to risk when alternative models of working were required due to capacity and demand issues. If staff were required to care for patients with mental ill health in addition to patients with significant physical ill health, the risk in relation to this was believed to be high. Prior to our inspection, we received concerns from staff members anonymously who had raised concerns in relation to the ongoing management of patients with mental ill health and the challenge this presented when caring for a patient who required frequent observations for their physical ill health. Despite staff raising these concerns, staff told us there was no visible action taken to manage these risks. The service was in the process of implementing the therapeutic observations and engagements for mental health (TOE) tool which would assist staff caring for patients with mental health needs.

Critical care

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. Safety huddles were conducted 3 times each day (8.30am, 5.30pm and 8.45pm). Specific safety issues were identified, and actions assigned to staff to ensure the safety of the department. Following the huddles, records of the meeting was shared with the wider critical care team to identify any significant safety concerns.

Following the management of surge capacity during the pandemic, the service looked at how they would safely surge the service during times of increased demand or during times when staffing was unable to meet the demand of the service (either through a staffing numbers or skill mix challenge). Surge refers to a time when the department comes under pressure and is required to expand to meet the demand. The alternative model of care was introduced in October 2022 and provided area managers with the tools to safely manage the demands on their service. Prior to this, the service had held patients in theatres or recovery until the service was able accommodate them. Staff told us when a decision was made to utilise the alternative model of care, a risk assessment was completed which aided the managers to decide on what changes were required, for example if there were patients requiring ward level care, they were cohorted together to free up staff who would then be able to accept a patient who required their specialist input. This had only been completed on the initial identification for the surge requirements, however staff had since realised this should be done throughout the surge, especially when there were any changes noted.

The service had introduced their own level 4 for patients who were undergoing invasive mechanical support or who had burns which extended beyond 40% total body surface. Patients who met level 4 status had additional support from another registered member of staff due to the level of risk they posed if they deteriorated suddenly.

The service provided a critical care outreach team (CCOT) who were available 24 hours each day, seven days a week. They supported ward staff around the hospital to provide care and treatment to critically ill and deteriorating patients.

Nurse staffing

The service had low nursing and support staff vacancies and managers regularly reviewed and adjusted staffing levels and gave bank and agency staff a full induction. However, there were challenges to ensure all areas had staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough nursing and support staff to keep patients safe. In June 2023, we were contacted by a number of anonymous whistleblowers who raised concerns about staffing within the service. The concerns identified there had been a significant turnover in staff and there were regular occurrences when staff were required to care for more patients than national standards recommended. During our inspection, we did not observe any concerns in relation to staffing on the day. All areas were adequately staffed to provide care and treatment for the number and dependency of the patients admitted. Information received after the inspection showed there was a total of 9.80 whole time equivalent (WTE) vacancies across all 4 critical care areas. Managers identified this was a small deficit in the numbers of staff. However, concerns centred around the skill mix of staff as a significant number of experienced staff had left following the pandemic.

The service had a stable turnover rate. All staff told us about the significant challenges which the service had been through due to a large number of staff leaving after the pandemic. However, the information shared by the trust showed the turnover rated had now stabilised to around 9%, which was lower than the trust average of 11.9%. Over the last 12 months, the service had lost 32 members of staff, with 12 staff leaving from critical care area D.

Critical care

The service had reducing vacancy rates. The service had worked hard to recruit staff since the large turnover after the pandemic. However, despite there now being a relatively low vacancy rate overall, critical care area D had the highest vacancy rates at 15.66 WTE. Information highlighted this was the area which had been most impacted by the pandemic with the number of staff leaving the service due to the nature of the speciality they cared for. Critical care area C also had a small vacancy for their establishment, however with staff who were due to start, this was reduced to almost zero. The service had rolling adverts for recruitment of band 4 registered nurse associates and band 5 registered nurses to maintain safe staffing levels across the whole of the critical care service.

There were no current vacancies within the 'unregistered' staffing establishment. The service was over their establishments for unregistered staff as this included the trainee nurse associates (TNAs) who were still in training. Once the training for these staff was complete, these staff would disappear from this establishment and on to the registered staff establishment. There were no reported gaps with the healthcare assistant (HCA) roles either.

The critical care service was also supported by military members of staff who provided the service with a further 5.0 WTE registered members of staff. Any additional military staff on shift within critical care were considered supernumerary due to other commitments and requirements placed upon them.

Managers calculated and reviewed the number and grade of nurses, nursing associates, healthcare assistants and trainee nurse associates needed for each shift in accordance with national guidance. The ward manager could adjust staffing levels daily according to the needs of patients. Staffing for each area was planned based on the funded level 3 equivalent beds they had. Information received indicated the critical care areas were rarely at full occupancy and therefore staffing could be reduced if acuity did not indicate a need for a fully staffed shift. The staffing mostly allowed for one-to-one care for level 3 patients and one to two for level 2 patients. This met the Guidelines for the Provision of Intensive Care Services (GPICS) 2022.

Staff told us due to the demand and the acuity of patients, there had been a requirement to look at how the service managed in times of pressure. In October 2022 the service introduced the alternative models of care policy which provided clinical nurse leaders with clear guidance for responding to the demands, pressures or staffing constraints within the service. When pressures were identified, clinical nurse leaders were required to complete risk assessments which indicated the level of risk (normal, flex, stretch and full stretch) and determined what actions were required within the department. During July 2023 information received from the trust showed there had been 12 shifts (out of 93 shifts) where the trust had escalated to flex, 2 shifts where the trust had escalated to stretch and 1 shift where the trust's critical care had escalated to full stretch. Examples of actions leaders took during times of flex, stretch or full stretch was 'pod modelling' approach where a group of staff would care for several patients (this could me a mixture of level 3 and 2 patients). Within the group of staff would be unregistered staff (TNAs and HCAs) who would support the registered staff assigned to the group. Another example would be cohort nursing of patients who were awaiting a bed on a ward (level 1 patients). These patients would be cared for by unregistered staff predominantly. In both scenarios, a registered member of staff would have the overall responsibility for the patients. The whistleblowers who came forward before the inspection and some staff on the day of inspection raised concerns over the implementation of this process, with some unregistered staff indicating they had been 'left' in charge of patients who they did not feel competent to be caring for alone. In addition to this, some registered staff raised concerns over caring for more than 1 patient despite having the support of either HCAs or TNAs (or both).

We escalated these concerns to the senior leadership team and requested additional information for assurance purposes in relation to unregistered staff who did not have the required competencies being left in charge of patients. Leaders provided information which demonstrated that the processes for staff to follow clearly indicated patients were the responsibility of the registered member of staff and unregistered staff worked under the supervision of registered

staff. The leadership team had also engaged with the unregistered staff to discuss these concerns. Feedback from these meetings did not corroborate our findings, with most staff only reporting how they felt supported when working under the alternative model of care. Leaders concluded there was a misunderstanding over the terminology of the alternative model of care and this had resulted in staff raising these concerns with CQC. It was noted that within the information submitted by the trust in relation to these concerns was a staff survey. The surveys asked those completing it to identify if they had been involved in an alternative model of care and if so, which type. Within the survey, a significant number of staff on each survey had indicated 'other' however there was no description as to what 'other' meant. This could indicate there were times when staff were not managing patients in line with the model.

The evaluation of this model had so far been mainly positive, although it was completed 1 month after its introduction when there had not been many instances of needing to surge and some staff were unaware of the new model. Senior leaders told us they were currently completing a new evaluation of the models of care. The staff feedback questionnaires provided balanced feedback about staff perception of the new model. The registered staff feedback from June 2023 indicated most staff thought the new model was ok and positive, however there were 5 staff responses which indicated concerns with this. The feedback from the TNAs in March 2023 indicated staff believed the new model was having both a negative and positive impact on their health and well-being (13 out of 23 responses) with 2 members of staff indicating it was only having a negative impact.

There were a number of meetings which occurred throughout the day which looked at the staffing for critical care and the demand on the service. A situation, background, assessment and recommendation (SBAR) report was prepared twice each day in advance of both the morning meeting and night shift to inform the team of any areas of concern which may require escalating.

The number of nurses and healthcare assistants matched the planned numbers. On the day of the inspection there were no staffing deficiencies identified. Information received after the inspection showed during July 2023, there were issues identified across all 4 areas. The information showed critical care area D was significantly challenged on 13 days during July 2023.

The service had a higher than trust average sickness rate. The service had an overall sickness rate of 5.63% between June 2022 and May 2023. This was over the trusts own key performance indicator of 4%. It was noted from the information provided that critical care area B was below the trust key performance indicator (KPI) for sickness with an average rate of 3.73%.

Managers did not limit their use of bank and agency staff. Managers made sure all bank and agency staff had a full induction and understood the service. All areas within the service were reliant on agency and bank staff to meet required staffing numbers. Each area had a number of shifts put out to agency and bank for them to fill, this ranged from 171 shifts on area B in August to 414 shifts on area A in July 23. Fill rates ranged between 53% and 94% with staff telling us that night shifts had a large proportion of agency and bank staff working on them as these shifts were perceived to be less risky. On shifts where there was a low uptake of agency and bank staff, the alternative model of care was an option for leaders to implement to ensure patients remained cared for safely. We reviewed the duty rota for all critical care areas for July 2023 and found overall, agency staff were used more for the night shifts. We also found there were 25 shifts where the total agency staff on duty was above 20% which is the recommended maximum by GPICS.

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 bank and agency staff a full induction.

Critical care

The service had enough medical staff to keep patients safe. The service reported having no gaps within the medical staffing rotas. Information showed they had 11 cardiac critical care consultants and 32 general consultant who covered the 'sessions of work' within the critical care service. However, information presented within the governance meeting minutes identified there were gaps within the junior doctor's rota as well as there being a small deficit within the senior medical staffing position due to university consultants having a reduced availability. The information provided after the inspection which specifically requested staffing details for the service did not identify any concerns with any variances within staffing. We spoke with junior medical staff who had recently started to work within the service and were working supernumerary.

The medical staff matched the planned number. At the time of our inspection, there were no concerns about any medical staffing gaps. However, the information received after the inspection did not include any information about staffing levels for any medical positions other than consultants.

The service reported no staff leavers for medical staff. The information provided after the inspection did not include information about medical staff who had left the service within the last 12 months.

The service reported no sickness, long or short term amongst the medical staff.

The service reported no use of locum staff in the last 3 months. However, managers could access locums when they needed additional medical staff. In the event of locum staff working within the service, managers made sure they had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The service always had a consultant on call during evenings and weekends. Staff told us there were 2 ward rounds each day which were consultant led. In addition to this, medical staff also joined the unit staff on safety huddles. All potential new patients were discussed with the consultants for each respective area and if admitted to the service were reviewed within 12 hours. There were appropriate arrangements for medical cover out of hours. Consultants were on call from home and were expected to be within 30 minutes of the hospital. A senior trainee with intensive care experience was on duty with the support of a junior trainee for each unit overnight. No concerns were raised over the availability of medical staff out of hours.

Records

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

Patient notes were comprehensive, and all staff could access them easily. We reviewed 6 sets of notes and found all notes were comprehensive and met the professional standards set by the General Medical Council and Nursing and Midwifery Council.

Most records for patients within critical care were recorded on the trust's electronic system. This meant when patients transferred to a new team, there were no delays in staff accessing their records. This also meant all staff providing care and treatment for the patient had immediate access to the patient's records. The only items which were not electronic was a lines chart (a document which recorded all invasive lines and dates they were inserted) and an accountability checklist. All observations, fluid balance, risk assessments and daily updates were recorded electronically. Staff told us this was much better than when they previously used large paper charts which they entered all details of the patients care and treatment on.

Critical care

The service completed records audits as part of the peer quality assurance visit. Information showed all areas scored highly in these audits. Compliance with the set of standards which they were measured against ranged from 91% to 100%. Where areas had not achieved 100%, there was no additional information provided to identify what the area of non-compliance was. There was also no action plan provided to identify what actions the service were required to take.

Records were stored securely. We did not observe any computers which were left unattended during our visit. We observed staff locking the computers they used when stepping away from them to prevent unauthorised access.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, standards for safe and secure management was not always complied with.

Staff followed systems and processes to prescribe and administer medicines safely. The trust had their own in-house electronic prescribing and medicines administration (EPMA) system. It provided information in one place including the patient's medical requirements, a medicine history and up to date information on prescribing. Where dose adjustments needed to be made for weight-based medicine prescribing, the system alerted the prescriber and calculated the correct dose.

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

Staff reviewed each patient's medicines regularly and completed medicines records accurately and kept them up-to-date. The service had pharmacy oversight with regular review of the EPMA for each patient, the medicines prescribed and administered. Staff told us they accurately recorded when they had administered medications and were required to enter codes when omitting a medication. The service regularly audited their missed doses for antimicrobials, enoxaparin (injection to prevent blood clots), non-antimicrobials and missed background insulin doses as part of the clinical dashboard measures. Where medication had been omitted, information received did not identify any omissions where staff had not entered any reason for the omission. The most common reasons why medications were omitted were: patient was away from the area, patient declined, or patient was nil by mouth. Where medications were identified as not in stock, staff were being encouraged to use the pharmacy locator service to ensure patients did not go without important medication.

Staff stored and managed all medicines and prescribing documents safely. Medicines were stored in locked clinic rooms with secure access to authorised staff. The service had designated pharmacy support staff who replenished stock medicines.

The ordering, storage and administration of controlled drugs was mostly in accordance with the Misuse of Drugs Act 1971 and the associated regulations. Controlled drugs were stored in a suitable locked container and the shift coordinators checked these during their shifts. Controlled drugs (CD) audits were conducted each quarter. Each critical care area had multiple CD cupboards which made compliance challenging. The most recent audits conducted at the beginning of August 2023, identified compliance ranged between 84% on critical care area C, base 2, to 100% on critical care area B, base 1. There was no target or standard identified with these audits. Common areas of non-compliance were in relation to staff not signing when medicines were carried forward in the CD book, inappropriate items stored in the CD cupboard, missing checks and administration of CDs not signed by 2 staff members.

Critical care

Staff completed medicine refrigeration checks to ensure the correct temperature. We found in critical care area A, the medicines refrigerator was above the maximum temperature 3 times in June 2023, once in July 2023 and twice in August 2023. The records did not always indicate what actions had been taken. Where staff had recorded actions, this only indicated pharmacy had been informed. Staff were not aware of whether any medicines which required removal due to the temperature increase and not all staff were aware this action may be required in such circumstances. The missed temperature checks and failure to escalate to the pharmacy team was an area frequently picked up on their internal audits. We also noted the room where medicines were stored was not being monitored for ambient room temperature and does not provide assurance medicines were stored at the correct temperature to maintain their effectiveness.

Safe and secure handling of medicines (SaSHM) audits were completed on a 6 monthly basis and had a target of 85% compliance. Information shared after the inspection showed all areas within the service had challenges with safe storage and management of medicines with compliance ranging from 65.6% to 84.8% compliance. Common themes identified included loose strips and vials stored, unlocked cabinets which stored medicines, unattended medicines and fluids, expired medications and liquid medicines being opened with no dates of opening on them.

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 .

Staff learned from safety alerts and incidents to improve practice. Medication errors were the second highest number of incidents in all areas apart from B. No additional details about the incidents were provided. Staff would pass on the details of any relevant safety alerts during the safety huddles for that area.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff told us they tried to ensure patients had the least restrictive methods applied when they were demonstrating challenging behaviours. If a patient did require medication to control their behaviour, staff told us this would be closely monitored and strict information about dose, intervals and maximum permitted dose for 24 hours would be recorded.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. 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.

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 spoke confidently around the incident reporting policy and what incidents should be reported. However, there was some concerns raised by staff that they no longer raised all incidents due to the perceptions of not being actioned. Staff no longer raised all incidents related to staffing as staff perceived there was no action taken in relation to these incidents.

Staff raised concerns and reported incidents and near misses in line with trust policy. Incident data between February and August 2023 showed there were 564 incidents raised by staff within all critical care areas. Most incidents raised were graded no harm (289) and low harm (265). There were 2 moderately graded incidents. Critical care area A had the highest number of incidents raised (214).

Critical care

The service reported no never events within the last 6 months. Following our inspection, we became aware of a never event which occurred within another critical care area which belonged to the trust, prior to the inspection date. However, no staff we spoke with were aware of the never event. We were therefore not assured managers shared learning with their staff about never events that happened elsewhere.

Staff reported serious incidents clearly and in line with trust policy. Between February and August 2023, information provided after our inspection did not identify any serious incidents which had been raised by the service.

Staff understood the principles of 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.

Staff told us they did not always receive feedback from investigation of incidents, both internal and external to the service. Staff were given opportunities to meet and discuss incident feedback and look at improvements to patient care. We observed team meeting minutes which identified an agenda item where incident feedback was discussed. Within 1 set of minutes, we observed feedback on a rising theme in relation to a loss of dentures. The feedback provided reminders about the process for managing patient property. However, it was noted these meetings did not always have high rates of attendance. It was therefore difficult to ascertain how staff who were not in attendance were able to learn from feedback of incidents. Staff told us they were busy during their shifts and therefore did not always have the time to check any emails or read minutes and notices.

Managers told us they investigated incidents thoroughly and invited patients and their families were involved in these investigations. When change was required, staff told us changes would be made as a result of feedback. However, no specific examples were provided.

Managers debriefed and supported staff after any serious incident. During our inspection activity, we became aware of a debrief which occurred with staff due to a significant and distressing incident which occurred within the service. The divisional director of nursing was in attendance to enable them to provide support to the staff who had experienced incident.

Is the service effective?

Outstanding ☆ ➔➔

The rating for effective is the rating from the previous inspection in May 2015. During this inspection we did not look at all aspects of the effective domain, we therefore had insufficient evidence to re-rate.

Competent staff

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

The numbers of staff with the required experience, skills and knowledge to meet the needs of patients was increasing. Managers made sure staff received any specialist training for their role. Following the pandemic, the service had a lot of experienced registered nurses leave who had completed the post registration qualification in critical care. The service

had worked hard to ensure staff had the post registration qualification and now all areas had at least 50% of their registered nurses with a critical care qualification, which was in line with GPICS standards. The service was planning to extend the number of registered nurses with the critical care qualification to boost compliance and ensure sufficient critical care trained nurses were available in the future.

There were specialist courses available for staff to complete to enhance their knowledge and skills when caring for patients with specific illnesses or conditions. Courses which were available for staff included the liver courses, cardiac courses, burns and trauma courses, neuro courses and major incident courses.

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

Managers supported nursing staff to develop through yearly, constructive appraisals of their work. Most staff told us they met with their managers for appraisals where they discussed their development. However not all staff felt these were always constructive and beneficial. Information received after the inspection showed there was an overall compliance rate of 89.8% for the service which was just about the trust target of 90%. Critical care area D was slightly below the 90% target due to 3 new staff who had started on the area but were not new to the trust.

Not all medical staff received their appraisal. Information shared with us after the inspection showed 70.8% of medical staff had received their appraisal. This was below the trust's target of 90%.

The clinical educators mostly supported the learning and development needs of staff. Clinical educators provided support to all new staff who joined the service as well as those undergoing training. The clinical educators worked alongside staff to help develop confidence and also assess their competence. Most staff spoke positively about the support they received from the clinical educators, with staff saying they had been patient with them and really understanding of their individual educational needs. However, some staff raised concerns about the response when they had contacted them for support. Staff at times had felt belittled and ridiculed and although this had been escalated, when it happened, to senior managers we were not assured it was always managed appropriately.

Managers held team meetings and encouraged staff to attend. Access to full notes were provided when staff could not attend. However, staff did not always have time to be able to read notes and email updates. We reviewed 3 sets of team meeting notes from each area and found them to be informative, however attendance was noted to be low during some meetings. During an interview with a member of the leadership team, they identified communication was an area where improvements were required, and they had found it difficult to capture the preferences of all staff. Staff had previously indicated while recognising attendance was low, they wanted the meetings to continue. Attendance at the meetings was opened to include teleconference options which staff could access from home, however this had not improved attendance. They were still looking at how best to engage with staff and would continue to seek feedback from staff on what their preferred options were.

Staff had the opportunity to discuss training needs with their line manager and managers mostly supported them to develop their skills and knowledge by giving them the time and opportunity to develop. Staff told us they had opportunities to discuss their training needs (outside of mandatory training) during their appraisals. However, they were not always given the opportunity to undertake additional training or study, training days were cancelled due to the needs of the service. There were staff however who were positive about their training opportunities, especially completing some of the specialist training courses relevant to their clinical area.

Critical care

Managers identified poor staff performance promptly and supported staff to improve. However, there were concerns raised about how this was managed at times and the response from staff when concerns were identified with their practice. Where performance concerns were identified, managers and clinical educators would work together with staff in a supportive manner to help them develop.

Is the service well-led?

Requires Improvement ↓↓

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

Leadership

Most leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. However, there was mixed responses from staff about leader's visibility and approachability in the service for patients and staff.

Critical care services came under the management of division 1 and had a triumvirate leadership of a medical director, director of nursing and managing director. There were also deputy directors for the division who were key in leading the service. Local leadership to critical care was provided by matrons, clinical leads and band 7 area managers who ran each of the 4 critical care areas.

There was mixed feedback about the approachability and visibility of the leaders of the service. There was positive feedback about the matrons who covered the service, however there was an awareness of the reduced number of matrons which meant 2 matrons were covering 2 areas had a large workload which appeared to be 'overwhelming' at times adding to the perceived lack of action taken when concerns were raised. Despite the matrons who were in place currently being thinly spread, staff told us they were visible. One of the matrons had been part of the service for a number of years and staff were comfortable in approaching them, especially those staff who worked in the original area they covered.

Concerns were raised by some staff about the approachability and visibility of some nursing leaders. Some staff told us they had tried to approach them before and had not received the support they required, they no longer had faith in their ability as a leader. Serious concerns had been raised, before and during the site visit about the approachability of a large number of the band 7 nursing staff who worked in the service. Some staff felt they had been 'verbally abused' in front of other staff members.

Vision and Strategy

The service supported the trust's vision and strategy. Leaders and staff understood and knew how to apply them and the division monitored their 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 which were based on the trust's objectives and values. 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.

Critical care

Culture

Staff did not always feel respected, supported and valued. Staff did not feel the service always had an open culture where concerns could be raised without fear. However, staff were focused on the needs of patients receiving care.

In June 2023, we received 10 anonymous whistleblowers raising concerns about staffing within the service and also a bullying culture. As a result of the concerns, we requested some information to assure us in relation to the concerns raised. Information received identified there had been ongoing cultural concerns which dated back to the COVID-19 pandemic. The information indicated that the pandemic had unfortunately amplified the cultural issues due to the stresses and burnout staff now experienced. The senior leadership had escalated these concerns and commissioned an external review of the culture and leadership of the service. The review was conducted in June 2021 and identified that a lot of the issues had arisen as a result of the relationships with some members of the service and some of the matrons. Although this had been raised by the external report, the matrons were not identified by the whistleblowers as the main area of concern. However, it was noted within the report in 2021 some band 7 staff were beginning to act in a way similar to previous concerns about the matrons. Following the review, the service engaged in workshops and listening events in an attempt to improve the culture within the service.

The information submitted identified the senior leaders were aware of the long-standing cultural issues, however we still had concerns about the service and the lack of apparent progress which had been made regarding the cultural concerns.

During our onsite inspection staff gave mixed feedback about the culture within the service. We found there were a number of staff who were positive about the area they worked in and the managers they had direct contact with. However, there were a number of staff who raised similar concerns to those we were notified about prior to the inspection. In addition to this, staff raised concerns over managers that worked in other areas who they had come into contact with when they were required to move to support areas which were understaffed.

Staff raised concerns over some of the band 7 managers for the service and the way they managed staff within the service. Staff told us of examples where they had been shouted at and verbally abused by band 7 managers, which had occasionally been in front of peers as well as relatives and patients. Staff reported feeling very anxious around some band 7 managers and had experienced bullying type behaviour. There were other concerns raised about how some band 7 managers had ‘leaked’ confidential information about staff, information which staff did not want sharing with others. Some staff told us band 7 managers involved in this type of behaviour singled out junior staff or staff who they were confident would not say anything which meant their behaviour continued. There had also been concerns over staff feeling they had no choice but to leave the service due to the bullying and threats made against staff and the ‘toxic’ culture which had seemingly been left to develop within the service. There had been occasions where staff were told to ‘shut up’ and ‘get on with it’ when trying to approach managers. This type of reaction had therefore disengaged a lot of the staff. Staff told us they knew which of the band 7 managers they could go to if they really needed to escalate something.

Staff told us they had tried to raise their concerns with band 7s who were not seen as part of the ‘bullying culture’. However, there had been no perceived action taken as a result of the concerns raised or dissatisfaction with the outcome of action (for example a member of staff never received an apology for their experience when shouted and swore at in front of their peers). This was an area of concern which was also identified within the critical care responses on the staff survey. There were staff who told us they had previously raised concerns with matrons and the deputy director of nursing for the division, however no perceived action had been taken.

Critical care

Staff were aware of the Freedom to Speak Up Guardian (FTSUG) and their team, however many of those who raised their concerns about the culture with us, did not feel comfortable with approaching them and were not confident any action would be taken even if they did speak with them. There were also professional nurse advocates (PNAs) who were able to provide support to staff. Band 7s were very knowledgeable of these individuals, however staff of other roles and positions did not provide any feedback in relation to the support they offered.

We fed back these concerns at the end of our inspection, those who attended were not surprised by the feedback. Although we did not find evidence of any of the cultural concerns impacting on patient care and treatment, there was the concern that eventually this may impact patient safety. In addition to the actions already taken, staff were unsure what else at this time could be done to improve the culture within the department. Leaders had engaged pro-actively with the trusts FTSUG who were working with the managers to try and implement some of the recommendations from the external review which would lead to an improved culture within the service.

Despite the challenges some staff faced in relation to the cultures of the service, staff were mostly complimentary about their peers and teams they worked with. Staff were also focused on delivering the highest standard of care to their patients.

Governance

Leaders operated governance processes, throughout the service and with partner organisations. Staff at higher levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, we were not assured information and learning was always disseminated.

There were governance processes 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. Critical care and outreach speciality meetings were held on a monthly basis and covered key issues within the service. The service also fed into a number of other performance and quality meetings which included (but not limited to) divisional preventing harm, divisional clinical dashboard review group and critical care weekly team meeting.

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.

Staff told us there were occasional team meetings held where they were updated on essential information. However, it was acknowledged these were not always well attended and therefore information from these meetings were also disseminated through emails which staff did not always have the opportunity to read. We reviewed minutes from a range of meetings which occurred across the service. This included separate band 7, 6, 5 and 2 meetings. It was noted that not all areas had meetings for all staff levels, for example no minutes had been supplied for a band 5 meeting within critical care area A. We also found there was no standardised process across the 4 areas and the minutes ranged from extremely detailed to very little information being recorded. Where the minutes were sparse, it was unclear how staff would be kept up-to-date on key factors. We observed within some of the minutes concerns raised by staff which were due to be escalated, however we were unable to track how this was escalated. In addition to the team meetings, each area held safety huddles which were additional opportunities to pass on key information and updates.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They mostly identified and escalated relevant risks and issues and identified actions to reduce their impact. However, a significant risk identified was not recorded on the risk register and performance data was not discussed at all levels.

Critical care

There was a risk register which covered all critical care locations across the trust. There were 13 risks identified on the risk register which included significant staffing gaps (medical staff, advanced critical care practitioners and dietitians), increased occupancy within side rooms leading to known infectious patients being cared for within the open critical care environment and risk of pressure damage. The top risk was incompatible syringe usage in an infusion pump which may lead to failure in medication delivery. There was evidence on the risk register and the governance meetings that risks were regularly reviewed and closed appropriately when all mitigation was complete.

The longstanding concerns within the service in relation to the leadership and cultural concerns were not included in the risk register. Considering the work to attempt to improve the culture including the external review and information shared with and by CQC no information was included in the risk register. Senior leaders were in agreement in relation to the risk this posed to patient safety and the care and treatment they received. We were therefore not assured all risks had been identified and shared appropriately within the division and the trust.

In addition to the above, there was no reflection of the concerns in relation to the risk of the increase in mental health patients. At the time of inspection, the service were still implementing specific mental health therapeutic observational and engagement tools and training levels were low. Staff reported they did not feel prepared to provide appropriate care and treatment to these patients, especially if they were required to care for level 3 patients at the same time. There had been incidents which staff told us about where the impact of not being adequately prepared to care for these patients had been raised as a concern.

The service used a clinical dashboard to monitor real time performance and used this data for instant improvements. The dashboard had 17 metrics which managers reviewed, this included completion of records, completion of malnutrition and other risk assessments, missed antimicrobials and missed enoxaparin to name a few. All metrics had a compliance rate which they were measured against and where standards fell, this was discussed at the speciality governance meetings for the service. We observed there were areas who were consistently red, amber and green (RAG) rated red for their performance on the metrics between June and August 2023. We reviewed minutes from divisional meeting to review how these challenges in performance were escalated and how the leadership team challenged teams for plans on how they intended to improve. However, the minutes did not indicate there was a thorough discussion around the performance of the areas and no identified actions from these meetings for the managers to implement to improve performance. There was also inconsistent information being cascaded down to the areas in relation to performance.

There was a programme of clinical and internal audit to monitor quality and operational processes, as well as assurance inspections/audits which were completed internally. The minutes of the speciality meeting provided detailed key findings; however, we were not able to track through to area level meetings that this information was always shared due to the inconsistent and lack of standardisation of the meetings.

Weekly mortality and morbidity meetings were held to discuss all deaths in the preceding 7 days. These meetings were mostly attended by the multidisciplinary team, although it was noted nurses were ‘invited to attend’ as well. This raised concerns over nurses not being identified as part of the MDT. The mortality and morbidity meetings had their details collated on a spread sheet and contained relevant details about the patient's death, however this did not always record attendees for the meetings. All deaths were discussed in relation to the General Medical Council guidance and where actions were identified, these were escalated accordingly.

Critical care

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.

Staff were able to access the trust intranet site to access any policies and procedures needed to carry out their roles effectively.

The service had a team of staff who collected data to inform national audits including Intensive Care National Audit and Research Centre (ICNARC). This was used to benchmark performance within the service against other critical care services across the country.

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 trust's staff surveys. Results showed the service scored 13 positive scores which were the same or better than the trust average, 17 scores up to 3% below the trust average and 67 scores 4% or more below the trust average. This meant the staff within the critical care areas were not as satisfied in their work compared to the average across the trust. Due to the awareness of concerns within the service, the results of the staff survey were not a surprise, and the senior leaders were already implementing work as a result of the external review which had already captured a lot of the concerns raised in the staff survey. Forty-three percent of staff reported they would recommend the organisation as a place to work and 82% of staff believed their role made a difference to those who used the service. The completion rate for this critical care service was 97 responses.

At the time of our inspection, the service had an open feedback system going on to provide feedback about the service as well as further evaluations of the alternative care model and it's implementation. Staff had reported the response rate for this was high and they were collating the data to enable them to discuss at future divisional and trust meetings and learn from any areas where improvements were required.

The introduction of the trainee nurse associate (TNA) programme had seen an impact on the staff engagement. Staff who had qualified as a registered nurse associate had gone on to develop further due to the benefits of what a role in critical care could offer them. Three of the nurse associates had now qualified as registered nurses.

Communication and engagement with staff was an area where most staff felt improvements could be made. Senior leaders identified there were various platforms where staff could engage, however these were not always successful. This had led to the introduction of VLOGs (video diary logs) from the senior leaders about key messages. There had also been an increase in 'away days' for staff to give opportunities to complete key skills and training as well as engaging with members of the service. The service was introducing a 'you said, we did' approach to feedback from staff. The service had also introduced a staff diversity board for all staff to engage with and celebrate the heritage of the diverse workforce within critical care.

The service leads had introduced a 'workforce appreciation' strategy. This included providing mentorship group socials where staff received a free meal following a day of mandatory training. This helped with team building and communication amongst the workforce. There was also 'pizza Fridays' where staff were provided with free pizza as a thank you. This occurred every third Friday.

Critical care

The service received a lot of feedback from patients and relatives, and we saw a lot of thank you cards within each area. The service also ran critical care follow-up clinics with patients which were nurse led and enabled patients to feedback their experience of critical care.

The service was part of the midlands critical care network and had hosted the Adult Critical Care Coordination Transfer Service (ACCOTS) for a long period of time. The service regularly engaged with the service to ensure they were providing patients with safe, effective and responsive, care and treatment.

Learning, continuous improvement and innovation

Staff wanted to improve their services and drive innovation and learning. However, staff did not always feel encouraged to share their ideas. The service was however, keen to participate in research.

The trust as a whole were very proactive in research and the service were keen participants in study's which advanced critical care. They were currently part of 5 external studies and 5 studies which were being ran internally. The service had recently joined a study which was looking into different models of staffing within intensive care. A study which had been concluded and a poster presentation completed for external transplant meetings reviewed the impact of social media to support post-transplant critical care service provision. The outcomes demonstrated that there had been an improvement in the support for patient care delivery and identified additional areas where improvements could be made.

An internal improvement project which was currently being completed was in relation to improving the experience for ventilated patients. This was being led by the physiotherapy team who worked with the nurses to empower them in their management of ventilated patients. The service had also recruited a critical care specialist tissue viability nurse after recognising an increase in the prevalence of pressure related damage.

The alternative model of care was viewed as an innovative way of improving the staffing challenges during times of increased demand so patients could continue to receive safe and effective care and treatment.

Staff did not always feel as though they were encouraged to share innovation and improvement ideas. Staff discussed examples of where they had ideas on how to improve the service by learning from situations both internally and externally. However, staff had become despondent due to their ideas not being taken on board or given the consideration they believed they deserved. This was also supported by details from the staff survey which showed only 52% of staff felt able to make suggestions to improve the work of their department and only 32% of staff felt able to make improvements happen in their area of work.