

University Hospitals Birmingham NHS Foundation  
Trust

# Queen Elizabeth Hospital Birmingham

## Inspection report

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## Ratings

### Overall rating for this service

Inspected but not rated 

Are services safe?

**Requires Improvement** 

Are services responsive to people's needs?

**Inspected but not rated** 

Are services well-led?

**Inspected but not rated** 

# Our findings

## Overall summary of services at Queen Elizabeth Hospital Birmingham

**Inspected but not rated** ●

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 combined organisation has a turnover of £1.6 billion and provides acute and community services across four main hospital sites:

- The Queen Elizabeth Hospital Birmingham
- Birmingham Heartlands Hospital
- Good Hope Hospital
- Solihull Hospital

The trust also runs Birmingham Chest Clinic, a range of community services and a number of smaller satellite units, allowing people to be treated as close to home as possible.

The trust has 2,366 in-patient beds over 105 wards in addition to 115 children's beds and 145 day-case beds. The trust operates 7,127 outpatients' and 304 community clinics per week. The trust has over 20,000 members of staff.

At the time of our inspection, the trust was 10 months into the pandemic response to COVID-19 with over 450 COVID-19 inpatients. A number of changes to services and ward specialties had taken place since March 2020 in response to the emergency to ensure the trust was able to provide care and treatment as appropriate to the increasing number of COVID-19 patients. Throughout the pandemic, University Hospitals Birmingham NHS Foundation Trust has had a consistently high number of COVID-19 inpatients.

Concerns have been raised through enquiries and serious incident reporting about medical care services at QEHB in relation to:

- Discharge processes and communication
- Venous thromboembolism (VTE) assessment and management
- Incident reporting and sharing of learning including Never Events
- Support, care and treatment for patients with learning disabilities
- Staffing
- Patient care and emotional support
- Infection prevention and control
- Allegation of staff bullying

# Our findings

These concerns led to a decision being taken to complete an unannounced (staff did not know we were coming) focused inspection on 2 December 2020. The inspection was carried out by two CQC inspectors and one specialist advisor. We inspected elements of the key lines of enquiry of safe, responsive and well-led. During our inspection we visited seven wards including the acute medical unit, general medical wards, haematology wards, the cardiology ward and a care of the older persons ward. We spoke with 24 staff including ward managers / sisters, registered nursing staff, student nurses, trainee nurse associates, healthcare assistants, and medical staff. We reviewed 44 sets of electronic records. Following our inspection, we held a virtual interview with managers for the medical care division and a virtual staff focus group with staff on ward 515 which was not visited during the inspection due to the risk of COVID-19.

Following this inspection we did not re-rate all key questions. We have only re-rated key questions where we identified a breach of regulation.

Our rating of this location stayed the same. We rated it as good because:

- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- Managers were aware of staffing pressures and regularly reviewed and adjusted staffing levels and skill mix, in order to mitigate staffing risks as far as possible.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- Staff had systems and processes for planning patient discharges and usually used these to ensure discharges were safe. They monitored the number of delayed discharges and worked as a multidisciplinary team to facilitate timely discharge.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. Performance data was used to drive improvement.

However:

- Staff did not consistently update venous thromboembolism (VTE) risk assessments for each patient when it was indicated.
- The service did not always have enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Leaders did not always operate effective governance processes, throughout the service. Although staff at all levels were clear about their roles and accountabilities, not all staff had regular opportunities to meet, discuss and learn from the performance of the service. There was not a consistent approach to sharing learning from incidents widely across the service.

# Medical care (including older people's care)

Inspected but not rated ●

Is the service safe?

Requires Improvement ● → ←

Our rating of safe stayed the same. We rated it as requires improvement because:

## Cleanliness, infection control and hygiene

**The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw that all staff were bare below the elbow and regularly washed their hands and used hand gel which was widely available on all wards. We observed staff decontaminating their hands before and after each new patient contact. All staff were wearing facemasks whilst providing patient care and when moving around the ward area. All staff and visitors to the hospital were required to wear face masks on entering the hospital building and to keep these on whilst moving around the hospital. We saw that staff wore appropriate PPE when providing patient care including gloves and aprons in addition to face masks. Disposable respirator masks (FFP3 masks) were used by staff when providing care to patients that had COVID-19 during Aerosol Generating Procedures (AGP) of the respiratory tract. AGPs included treatments such as Non-invasive ventilation (NIV), Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP). Staff had been face fit tested for FFP3 masks to ensure they could achieve a suitable face fit of the mask and that it operated at the required efficiency to protect themselves, and other patients, from the risk of transmission of the virus.

## Assessing and responding to patient risk

**Staff did not consistently update venous thromboembolism (VTE) risk assessments for each patient when it was indicated. VTE risk assessments were not reviewed by consultants in line with national guidance. However, staff mostly completed initial risk assessments for VTE and appropriate treatment was usually provided to remove or minimise risks.**

Staff completed VTE risk assessments for each patient on admission / arrival, using an electronic risk assessment tool. The system prompted staff to complete the risk assessment. Staff told us that medical staff were responsible for completing the risk assessment. We reviewed 40 notes for completion of initial VTE risk assessment and found that it had been completed in 39 of these. The hospital completed a snapshot audit of VTE assessment on each ward every quarter. The latest audit data available for quarter three 2020 showed that an initial VTE assessment had been completed within 24 hours of admission in 29 out of 30 records reviewed.

However, we found that staff did not always regularly review the VTE risk assessment when this was indicated. VTE risk should be reviewed in order to decrease the risk of hospital acquired thrombosis. Hospital acquired thrombosis covers all VTE that occurs in hospital and within 90 days after a hospital admission. NICE guideline [NG89]: Reducing the risk of

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hospital acquired deep vein thrombosis or pulmonary embolism (2018) recommends that all medical patients are assessed to identify the risk of VTE and bleeding as soon as possible after admission to hospital or by the time of the first consultant review. All medical patients should be reassessed for the risk of VTE and bleeding at the point of consultant review or if their clinical condition changes. In the 40 records we reviewed, only four patients were identified as requiring a review of their VTE risk and of these, one review was completed and three were not completed. In none of the 40 records we reviewed did we find evidence of a consultant review of the VTE risk assessment. We raised our concerns around VTE risk reassessment with the trust following our inspection. They told us that decisions of no change, in relation to VTE management, were not required to be made explicit in a patient's record.

Staff usually provided appropriate treatment for those patients identified as being at risk of developing a VTE. In the 40 records we reviewed we found that in 20 cases, appropriate treatment was prescribed and administered, in 17 cases treatment was not applicable and in three cases treatment was prescribed but not always administered. These three cases were all on the same ward. In one case treatment had been paused but not reviewed for the need to be restarted. This meant the treatment may not have been given when it was required. In another case, the need for an increased dose in medication had been identified by pharmacy staff but this increased dose had not been prescribed or administered. In the third case, a VTE risk had been identified on initial assessment but no treatment had been prescribed by the medical staff. Following our inspection, we raised our concerns about the lack of evidence of review of VTE assessments with managers. We identified that the decision-making process was not clear in the patient's records and documentation of clinical decisions made could be improved. In response, managers told us that a detailed senior medical review of each of the patient records we had looked at had been performed. They gave assurance that appropriate clinical decisions had been made regarding the stopping of anticoagulant medication. The trust's response stated that where a patient's VTE prophylaxis medication had been suspended, the decision to continue with the suspension of VTE prophylaxis was implicit in the medical record even if it was not made explicit. Managers at the hospital told us that a new functionality within the electronic records system was being introduced in January 2021 which would alert doctors of the need to re-evaluate all patients who had not had prescribed anticoagulant medication administered for 72 hours.

The hospital provided results of VTE audits. The quarter three 2020 hospital snapshot audit of VTE results showed that in all the records reviewed prophylactic medication to reduce the risk of VTE had been prescribed where appropriate.

The hospital had reported a number of serious incidents relating to VTE management through the trust's electronic reporting system which indicated that patients had experienced avoidable serious harm. From August 2019 to June 2020 we identified 17 incidents reported across the trust through the national reporting and learning system (NRLS) where there was some element of mismanagement of the VTE process. Six of these incidents identified that the mismanagement had resulted in potentially avoidable venous thromboembolisms in patients.

Overall, we were not assured that processes for risk assessment and management of identified VTE risk was always completed in a way that ensured patients were kept safe from the risk of harm.

During our inspection we found that staff shared key information to keep patients safe when handing over their care to others. We saw that there was a nurse discharge checklist within the electronic patient record system, and this was used consistently. The checklist included actions such as providing discharge information to patients, discussing patient care with the family and making referrals on to community services. Staff had to tick boxes within the checklist to indicate these actions had been completed. A summary document about each patient's hospital stay was sent electronically to GPs and a copy was printed out for patients to take home. The summary included information about the patient's medical condition, treatment and current medication. In the 40 records we reviewed we found that the discharge

# Medical care (including older people's care)

checklist had been fully completed in 19 cases. In the remaining 21 records this was not appropriate to complete as the patient had not yet been discharged. We also saw evidence in all records we reviewed, that, where appropriate, there had been communication with patients and their family or carers before discharge to ensure that important information was shared.

Shift changes and handovers included all necessary key information to keep patients safe. All wards had a nurse handover between shifts to share up to date information about each patient's condition and treatment. Following the handover there was a daily 'shift expectation' activity on most wards which was used to share information with all staff including important updates and reminders about expected behaviours.

## Nurse staffing

**The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers were aware of staffing pressures and regularly reviewed and adjusted staffing levels and skill mix, in order to mitigate risk as far as possible.**

The service did not always have enough nursing and support staff to keep patients safe. On every ward we visited during our inspection, staff consistently told us that they were short staffed. Registered nurse to patient ratios were often one to nine during the day and one to 12 during the night shift. Staff told us that wards felt busy but that they could manage the workload. Staff described occasions when care may be delayed, for instance medication rounds running late, but staff told us that they worked together as a team to support each other in delivering safe care. During our inspection, we did not see any evidence of delays in care provision. We asked staff if they felt able to escalate concerns about staffing and all staff we spoke with confirmed that there was a process for raising staffing concerns. Following our inspection, we asked for information about incidents reported relating to staffing concerns on the wards we visited during our inspection. There had been 31 incidents reported from September 2020 to November 2020 which related to staffing issues. 30 of these incidents were graded as no harm, and one as low harm, where a patient's intravenous medications were delayed.

We reviewed the divisional risk registers to see if staffing had been identified as a risk across medical care. There were 11 risk registers covering the different medical specialties and six of these identified staffing as a risk. Each staffing risk had been rated as moderate. Risks identified were high vacancies / shortages of nursing staff on particular wards and the risk of some delays in treatment and care. We saw that most of the staffing risks had been on the risk register for more than a year with one identified in 2016. Since these risks had not been removed from the risk register, we understood them to be current risks. There was no date to evidence when the risks had last been reviewed.

The actual number of registered nurses per shift did not usually match the planned numbers, whilst the actual numbers of health care assistants (HCA) regularly exceeded planned numbers. Staff told us that it was commonplace for gaps in registered nursing shift cover to be filled by additional health care assistants. This meant that overall staffing numbers remained the same but that the skill mix was adjusted. On wards that provided medical care to older people, staff felt that it was a positive to have more HCAs as they provided appropriate support to registered nurses to meet the care needs of this patient group. Following our inspection we requested data relating to planned versus actual staffing numbers. This showed that from September 2020 to November 2020, 72% of registered nursing shifts were filled during the day and 82% of registered nursing shifts during the night. However, this was balanced by shift fill rates for HCA staff being over filled at 118% during the day and 174% during night shifts.

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On the haematology wards, staff raised concerns around the availability of numbers of suitably qualified staff. One ward that provided care for haematology patients, had recently changed specialty from being a urology ward. Whilst some of the staff from the urology ward had moved to a different location to continue providing care to urology patients, others had needed to develop new knowledge and skills in providing care to haematology and oncology patients. This was since two wards were working together as one unit to provide care to patients receiving chemotherapy and bone marrow transplants. Some staff did not feel confident in working in this environment and not all staff had received the required training to develop the new skills required. However, managers told us that there was a plan for all staff to be fully trained and competent by the end of January 2021. Managers planned rotas so that staff worked across the two haematology and oncology wards to ensure that suitable competent staff were always available on shift.

Managers reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance. Staffing was regularly reviewed across the hospital by the matrons, deputy director of nursing and the divisional director of nursing who met together three times daily to mitigate risks as they arose. Information about staffing levels was collated in a staffing dashboard so managers could easily identify the areas of greatest need. Acuity levels were considered alongside staffing numbers but managers told us that all areas were experiencing high acuity at the time of our inspection as a result of the impact of the COVID-19 pandemic and winter pressures. During the second peak of the pandemic staff movement between wards was high as bed numbers and front door activity fluctuated and there was a need to cover staff absence due to sickness, isolation and shielding. Managers allocated nursing staff to any areas of short staffing or particularly high acuity taking a hospital site wide approach to safe nurse staffing levels.

Managers were aware of the staffing concerns and told us they had a range of actions in place to mitigate the risk of reduced staffing numbers on shifts. On each ward there was a band six nurse in charge of the shift who was supernumerary and could perform clinical work to support the rest of the team when required. We were told that it was commonplace for the band six to provide patient care rather than remain in a managerial role for the shift if staffing was short. There was a pool of nursing staff available to the hospital who were rostered to work but were not allocated to a specific ward. These staff were allocated to the area of greatest need identified in the divisional directors of nursing's daily meetings. Consideration was also given to skill mix available to support such as therapy blended workers and nursing students who could provide mitigation for lower staffing numbers. Across the trust a significant number of student nurses in their last six months of training were deployed into paid placements as pre-registration nurses. These staff were added to the HCA section of the roster and there were 131 of these staff in post in October 2020 which therefore helped to mitigate the registered nursing gaps. In addition, there were 294 trainee nursing associates (TNAs) within the HCA workforce who were at varying stages of their apprenticeship. A TNA is a highly trained, generic, nursing support role designed to bridge the gap between HCAs and registered nurses to deliver hands-on, person centred care as part of the nursing team. TNAs at the hospital were able to provide further skills to help mitigate the registered nursing gaps.

The medical care service had average vacancy rates from September 2020 to November 2020 of 8% for registered nurses and 0.3% for HCAs. There was no trust target for vacancies.

The medical care service had average sickness rates from September 2020 to November 2020 of 8.4% (combined figure for registered nursing and support staff). This was higher than the trust target for sickness, which was 4%.

Managers limited their use of bank staff and did not routinely use external agency staff. Additional staffing requirements for short staffed shifts were sourced from an internal trust wide bank of staff who were all familiar with the hospital and wards.

## Incidents

# Medical care (including older people's care)

**The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents. However, there were not consistent processes on all wards for sharing lessons learned with the whole team and the wider service.**

All staff knew what incidents to report and how to report them. Staff we spoke with told us they had access to an online incident reporting system and were able to give examples of what they would report as an incident. Managers told us that there was a positive culture amongst staff for reporting concerns as incidents. Staff raised concerns and reported incidents and near misses in line with trust policy. Nurses, healthcare assistants and medical staff all told us that they felt confident to raise concerns with managers and report incidents.

Staff did not consistently receive feedback from investigation of incidents, both internal and external to the service. Some staff told us that they received feedback verbally or by email following submitting an incident report. However, not all staff described receiving feedback following reporting incidents.

Managers shared learning from incidents through a variety of routes, although processes for sharing information were not consistent across the service. Ward level staff meetings did not routinely happen across the service. Managers explained that face to face meetings for groups of staff had become more difficult during the COVID-19 pandemic. However, some staff we spoke with told us that ward meetings had never been routine. Where staff did describe ward meetings happening, we found there was no set agenda. Ward managers told us that agendas were set in an ad hoc way depending on what issue needed discussing at the time of the meeting. Incidents were not, therefore routinely discussed at meetings to share concerns and learning with staff. Staff and managers described other ways in which learning from incidents was shared, including discussion at shift handover meetings and safety huddles, ward manager's emails, screensaver messages on the hospital's computers, bulletins on the trust intranet and ward patient safety boards. Safety huddles were used to communicate relevant information relating to patient issues and the sharing of any key clinical messages. There was a shift expectation document used on some wards to deliver this information consistently. The same one was used for a week to ensure all staff had heard the same messages. In addition, we saw that there were patient safety and learning lessons communication boards on some wards where important safety messages were displayed. Whilst information was available to staff through these routes, there was a lack of consistency in the approach for sharing information at ward level.

Managers told us that clinical incidents were discussed at 'prevent and harm' divisional meetings which all levels of staff were invited to attend. Not all areas held prevent and harm meetings as some incorporated this information into divisional quality and safety meetings. We saw that minutes from prevent and harm meetings included presentations of case studies and learning to be shared. However, minutes from quality and safety group meetings did not demonstrate that learning was routinely shared. We found that there was an inconsistent approach to the sharing of learning from incidents at divisional level meetings. Managers told us there was a trust wide nursing quality and monitoring group where serious incidents were reviewed and learning was shared. We saw that agendas for these meetings identified a list of serious incidents to be discussed, although there was no record of the learning identified or actions required from these meetings. Managers explained that it was generally band seven staff and above who attended these meetings. Band seven staff (ward managers) met regularly with the site director of nursing, where we were told any learning from incidents was shared. However, these meetings were not minuted so we could not confirm this. We saw that there were weekly matron's meetings for information sharing which were minuted. There were some rolling agenda items for these meetings but incidents was not one of these items. There was an expectation that matrons and ward managers would share information from these meetings with staff through the processes described. Managers told us they were assured



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that staff had feedback and information that was relevant to them. However, we were not assured that there were consistent processes in place for sharing of learning from incidents across the division. This meant that not all staff may receive the same information and that key messages for learning from incidents may not be shared as widely as possible.

There was evidence that changes had been made as a result of learning from incidents. Staff were able to describe some examples of when learning had been shared and new processes had been implemented. These included raising staff awareness of patients on a soft diet through clearer communication and training from the dietitians and implementing a system to ensure outstanding patient risk assessments are identified and completed.

The service had three never events on the haematology wards from October 2019 to November 2020. All related to patients receiving wrong blood transfusions. Findings from the never event investigations identified a series of individual staff errors through failure to follow trust processes. Although the patients involved in these never events experienced some adverse reactions, these were reversed and no long term harm was sustained.

Managers shared learning about never events with staff in their area, however, there was no evidence that never event learning was shared more widely across the trust. Staff we spoke with on the haematology wards were aware of the never events and the learning identified from these. They described actions that were put in place following the learning from the never events which included staff training, updating treatment protocols and removal of a local blood fridge. Staff on the other medical wards were unable to tell us about the haematology never events and told us they were not aware of any recent never events in the medical care service.

Managers did not routinely share learning with their staff about serious incidents and never events that happened elsewhere. There was no process in place for consistent discussion of trust wide serious incidents and never events with staff since there were no regular staff meetings with set agendas. However, senior managers told us that such information was shared with all staff through chief executive briefs and all staff team briefs on the trust intranet. We were not assured that all staff consistently accessed this information and were therefore not always aware of relevant never events learning across the hospital.

## Is the service responsive?

Inspected but not rated



### Meeting people's individual needs

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

Staff made sure patients living with learning disabilities received the necessary care to meet all their needs. All staff we spoke with were aware of any patients on their ward who was living with a learning disability. Information about any patients with additional support needs was communicated at each shift handover. There was a learning disabilities specialist team based in the hospital who could visit wards and provide additional support and advice to staff caring for patients living with a learning disability. This team worked across the hospital and community settings which enabled information to be shared between services. The team flagged any known patients living with a learning disability on the electronic records system which meant they were automatically made aware when any of these patients were admitted to the hospital. Staff on the ward could also email the team or make a referral to the team through the electronic patient

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records system. The team offered an advice line for staff which was manned from Monday to Friday from 8am to 4pm. There was a strategy for meeting the needs of patients living with a learning disability and a set of standards for patients which had been written based on national standards. A link worker system had been developed across the trust to support the learning disabilities team. One hundred and twenty link workers had been trained in additional competency-based skills around supporting the needs of patients living with a learning disability.

Communication support aids such as picture charts, communication books, and easy read versions of information were used to facilitate conversations between staff and patients. Staff were able to describe examples to us of how they had supported patient's individual needs. Examples included staff using an electronic tablet device with a patient to enable them to make video calls with their family and enabling a patient's mother to be present during doctor's ward rounds to help the patient understand the information communicated.

We reviewed four sets of records of patients living with a learning disability who were inpatients at the hospital during our inspection. There was an admission checklist for patients with a learning disability to prompt staff to complete relevant assessments and make appropriate referrals. We saw that in all four records we reviewed, patients had been referred to the hospital's specialist learning disabilities team. There was evidence of referrals being made, where appropriate, to other services such as speech and language therapy, occupational therapy and dietetics. Mental capacity assessments were completed and documented for all four patients and deprivation of liberty safeguards were completed where needed. Do not attempt resuscitation documentation was completed where appropriate and there was evidence of involvement of relatives in the decision making process.

Multidisciplinary meetings were held for all patients living with a learning disability within 72 hours of admission which included the patient and their family / carers. This was to ensure appropriate care was in place and any additional support needs required on discharge were identified.

Staff supported patients living with learning disabilities by using 'all about me' documents and patient hospital passports. However, these were not always fully completed for all patients. On some wards there was an information board behind patient's beds to identify any additional support needs such as assistance with communication or eating. Staff told us that they involved patients and their family / carers in completing the 'all about me' document. This provided information about a patient's preferences for care if they were living with a learning disability and found it difficult to express these. The booklet helped patients identify their likes and dislikes, normal routines for personal care, and any communication support needs so that staff could provide appropriate individualised care. We asked staff to show us the completed hospital passports of any patients on the ward who were living with a learning disability. Only one patient had a passport document and we saw that this was not fully complete. Staff told us that although they try to complete the documents, they do rely on input from family and as visiting was restricted due to the COVID-19 pandemic there had been less opportunity to involve family in completing the document.

## Access and flow

**Staff had systems and processes for planning patient discharges and usually used these to ensure discharges were safe. They monitored the number of delayed discharges and worked as a multidisciplinary team to facilitate timely discharge.**

Managers and staff worked to make sure that they started discharge planning as early as possible. For patients with complex needs, such as older patients with multiple pathologies and patients living with a learning disability, staff held regular multidisciplinary meetings where discharge planning was discussed. These meetings involved medical, nursing and therapy staff. Managers we spoke with described a strong multidisciplinary team (MDT) working approach and

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explained the trust were supportive of MDT decision making around discharge rather than it being a medically led process. A complex discharge team offered further support in planning the discharge process for patients with additional support needs. For less complex patients, doctors and nurses discussed patient's medical fitness to be discharged on daily ward rounds. All patients were reviewed by a consultant before the decision to discharge was made. Doctors completed a discharge summary and any prescriptions for medicines required to take home.

Some wards had discharge coordinators to support nurses with planning the discharge process such as arranging transport, care packages or referrals to community services.

Staff generally planned patients' discharge carefully, particularly for those with complex needs. There was a discharge checklist document within the electronic records system which was used on most wards we visited. There were two versions of the checklist, one for complex patients and one for simpler discharges. The checklists required staff to tick boxes to indicate actions had been completed. Actions included providing information to patients and family about their ongoing care, removing peripheral vascular devices, making referrals on to appropriate community services, arranging any care package required and providing any equipment or dressings. In the 40 records we reviewed we found that the discharge checklist had been fully completed in 19 cases. In the remaining 21 records this was not appropriate to complete as the patient had not yet been discharged.

However, before our inspection we received information relating to concerns about discharge planning. From January to October 2020 we received 17 enquiries of concern about unsafe or poor discharges. Themes identified included poor communication with receiving care services, medication issues, and patients being medically unfit for discharge and requiring readmission. We asked staff and managers why they thought there were problems with poor discharges. Some staff told us that the use of the discharge checklist could be a 'tick-box' exercise. They explained that some staff, when discharging a patient, did not always take the actions required when ticking the check box. This was since they may be pressured for time or may have made an assumption that another nurse looking after the patient had previously completed the action. Managers also told us that discharge failings were largely down to individual failings due to staff making assumptions that other staff had completed tasks on the checklist. Following our inspection we asked for further information relating to the use of discharge checklists. The hospital told us that the use of the discharge checklist was not routinely audited. However, there were three standards relating to discharge planning in a new programme of a nursing inpatient documentation audit. The audit had been developed in line with trust nursing documentation standards and was a trust wide approach. Audit questions related to evidence of referral (when appropriate) to multidisciplinary team members, involvement of patients and family / carers in discharge planning, and completion of formal assessment forms for discharge where appropriate. We asked for compliance data with discharge audit standards but leaders told us that the data collection had not started until November 2020 and was on-going. They were not able to share nursing inpatient documentation audit outcome reports at the time of our inspection.

Within the medical care service at the hospital, from September 2020 to November 2020, there had been 100 patients readmitted to hospital within 72 hours due to failed discharges. This was out of a total number of 3,175 patient discharges, representing just over 3% of all discharges.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. There was an older person's assessment liaison team who worked with staff to facilitate timely discharge and prevent unnecessary admission. Data provided by the hospital showed that there were four stranded patients on 14 December 2020. This meant that these patients had been in the hospital for more than seven days and were assessed as being medically fit for discharge. Reasons for delayed discharges commonly included waiting for social care packages or residential care placements. There were no super stranded patients; these are patients who had been in hospital for more than 21 days and were medically fit for discharge.

# Medical care (including older people's care)

## Is the service well-led?

Inspected but not rated ●

During our inspection, we spoke with staff and patients. We found a positive culture of care.

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.**

Staff we spoke with told us that they felt supported by their colleagues, ward managers and matrons. They described a team approach where there were positive working relationships between all staff. One ward manager explained that staff morale had taken a dip during the latest peak of the COVID-19 pandemic and they recognised the need to offer additional support to staff during this time. Social virtual activities had been set up on the ward to improve staff's team spirit. There was also a mindful wellbeing hub at the hospital which offered mental health support for staff through liaison nurses.

Doctors, nurses, support workers and therapy staff respected each other and worked together well with a patient focused approach to care. Junior doctors we spoke with said that consultants were approachable and that they were able to be easily contacted out of hours for advice.

Ward managers explained that the matrons were the link between the ward staff and senior nursing leadership team. Ward managers and sisters met with the associate directors of nursing monthly in order to raise issues and share information. Although staff said they did not routinely see the senior leadership team on the wards as they worked across different sites, they described regular virtual contact through telephone and conference calls and emails. Staff told us that the senior nursing team were approachable and easily contactable.

Although we found the culture to be positive overall, there was some discord on the haematology wards which had undergone a recent change. Two wards had been joined together to work as one haematology / oncology unit and some staff were still struggling to cope with this change and were unhappy. One of the wards had previously been a urology ward but these services were moved to a different trust site. Some staff we spoke with on the haematology wards both during and after the inspection were unhappy with how the changes had been managed. They told us they did not feel listened to and that senior managers did not understand the impact of the changes on staff. The senior nursing team recognised that some staff had found the change difficult and were finding their new working environment difficult to cope with. Staff support had been offered from the psychology team and there was an ongoing training programme delivered by the haematology consultants. There was recognition that the change had been uncomfortable for some and would take some time to embed.

Before our inspection, we received information about potential staff bullying. We explored this during our on site inspection and found no evidence to substantiate this.

## Governance

**Leaders did not always operate effective governance processes, throughout the service. Although staff at all levels were clear about their roles and accountabilities, not all staff had regular opportunities to meet, discuss and learn from the performance of the service. There was not a consistent approach to sharing learning from incidents widely across the service.**

# Medical care (including older people's care)

There was an inconsistent approach to sharing governance information across the service. Different divisions within the medical care service used different processes. This meant that not all staff within the service received the same information in the same way at the same time. There was a lack of meetings at ward level with structured agendas which addressed governance issues such as performance, incidents and risks. We understood that ward meetings had been more difficult due to requirements for social distancing as a result of COVID-19. However, there were no alternatives in place to ensure that all staff received information about incidents, performance and risk in order to learn from these and make improvements. Where meetings did happen, there was often no set agenda which included rolling items to discuss governance issues. Agendas were ad hoc meaning that different wards had different meeting formats and did not discuss the same information. Ward level meetings, meetings between senior ward staff and the senior nursing management team, and daily meetings between matrons and the senior nursing team were not routinely minuted.

At a management level, there were a range of meetings for senior staff which covered governance, safety and quality issues. However, each division had different meetings which followed different agendas and there was not a consistent approach to sharing this information at a senior level. We saw minutes of divisional quality and safety meetings, prevent and harm meetings, speciality performance meetings and divisional senior management team meetings. Although we found that these meetings happened and governance items were discussed, the frequency and agendas varied between different meetings. Set agendas were not the same in each division which meant that there was not a consistent approach to sharing governance information across the medical care service.

There was not a consistent approach to sharing information and learning from incidents, performance data and identified risks widely across the service.

## Management of risk, issues and performance

**Leaders and teams used systems to manage performance effectively. Performance data was used to drive improvement. Leaders identified and escalated relevant risks and issues and identified actions to reduce the impact of identified risks. However, they did not always regularly review risks on the risk register.**

Performance data was routinely collected across the service and collated in an electronic performance dashboard. The dashboard provided oversight of performance in delivery of patient care such as falls, pressure ulcers, missed medicines and completion of risk assessments. Clinical indicators were identified to measure performance against and this was presented in a table so that performance over time could be reviewed. Each indicator had a drilldown option of more detailed data that senior nursing staff could access in order to investigate any performance issues. Colour coded (red, amber, green) targets were set to measure performance against each clinical indicator.

Ward managers and sisters had access to the dashboard and could take screenshots of performance compliance to share with staff. On some wards the performance dashboard information was shared by email or at shift handover meetings, where areas for improvement were identified. However, on some wards the information was not routinely shared with staff.

The performance dashboard was reviewed across the trust for any compliance concerns which were then challenged by a clinical dashboard review group. The group usually met monthly although this had been paused during the COVID-19 pandemic. If a ward was identified as having performance concerns, the ward manager was invited to a meeting of the group to present and explain their performance. The purpose of the group meetings was to identify barriers to meeting quality indicators where performance was identified as poor, and to identify and implement any actions required to

# Medical care (including older people's care)

improve. We saw that an action plan for improvement was produced which identified the problem, action required, persons responsible and due date for completion. There was also a requirement to describe how ward managers would evidence that actions had been completed. The group was described as a learning environment to improve performance.

We reviewed the service risk register which consisted of 11 separate risk register documents covering different medical specialties. Risks identified were scored and risk rated as low, medium or high. They had a target reduced risk score to be achieved and a named risk owner. There were separate risk register action plans which detailed a description of actions to be taken, including due dates and completion dates for actions. We saw that many risks had been on the risk register for more than a year with one opened as long ago as 2014. There were no dates on the risk register documents to evidence when each risk had last been reviewed. We were not assured that risks were regularly reviewed to establish if they still needed to be on the register as an open risk.

## Areas for improvement

Following our inspection we found the following areas for improvement:

The provider **MUST** ensure that:

- The provider must ensure that VTE initial risk assessments and VTE review assessments are consistently completed for all patients and that these are clearly documented. Regulation 12 Safe care and treatment (1) (2).

The provider **SHOULD**:

- The provider should consider taking a more consistent approach to sharing of governance information. Sharing of learning from incidents and performance data to drive improvement should be consistently shared with all staff in a standardised way across different divisions
- The provider should review their risk registers to ensure that all risks identified are still open risks and dates for routine review of risks on the register should be identified
- The provider should continue to review nurse staffing levels so that there are adequate numbers and skill mix of staff on each shift to keep patients safe and meet patient care needs
- The provider should consistently complete 'all about me' documents in full for all patients with additional support needs such as a learning disability

# Our inspection team

The inspection was carried out by two CQC inspectors and one specialist advisor.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

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