

Norfolk and Norwich University Hospitals NHS Foundation Trust

Norfolk and Norwich University Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital

Requires improvement



Urgent and emergency services

Good



Medical care (including older people's care)

Requires improvement



Surgery

Requires improvement



Critical care

Good



Maternity and gynaecology

Requires improvement



Services for children and young people

Requires improvement



End of life care

Requires improvement



Summary of findings

Outpatients and diagnostic imaging

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

The Care Quality Commission (CQC) carried out a comprehensive inspection between 10 and 13 November 2015. We also carried out unannounced inspections on 20 and 25 November 2015. We carried out this comprehensive inspection at Norfolk and Norwich University Hospital NHS Trust as part of our comprehensive inspection programme.

This organisation has two main locations:

- Norfolk and Norwich University Hospital, a large acute hospital comprising all acute services.
- Cromer Hospital which offers surgical and outpatients' services.

We also inspected Henderson unit as part of the unannounced inspection on 25 November 2015.

The hospital opened in late 2001, having been built under the private finance initiative (PFI). Cromer and District Hospital was rebuilt by the Trust in 2013.

The Trust provides a full range of acute clinical services plus further private and specialist services. The Trust has 1237 acute beds and It provides care for a tertiary catchment area of up to 822,500 people from Norfolk and neighbouring counties. The hospital also has an important role in the teaching and training of a wide range of health professionals in partnership with the University of East Anglia, University Campus Suffolk and City College Norwich.

Previous unannounced responsive inspection by the CQC took place between the 4th and 6th March 2015. The inspection focused specifically on accident and emergency services, capacity and demand, medical care and cancer services, surgery, and overall leadership of the trust. As this was a responsive inspection there are no ratings attached to our findings. However, concerns were raised about governance arrangements, Mattishall ward, the Fit and Proper Persons regulations and the bullying culture.

The trust had a relatively new executive team. The Chief Executive was appointed substantively in October 2015. At the time of inspection three other members of the team were interim positions; the Chief Operating Officer, Medical Director, and Director of Finance.

The comprehensive inspections result in a trust being assigned a rating of 'outstanding', 'good', 'requires improvement' or 'inadequate'. Each section of the service receives an individual rating, which, in turn, informs an overall trust rating.

The inspection found that overall; the trust had a rating of requires improvement.

Our key findings were as follows:

- Staff were overwhelmingly caring in delivering care to patients. We witnessed some outstanding examples of care being given to patients and their relatives.
- There were shortages of nursing staff that impacted on care provided throughout the hospital.
- There were some areas where there were medical vacancies which impacted on care. Most notably in the palliative care team and in the critical care complex.
- Incident investigation and root cause analysis was not always completed by those with extended training.
- The security on the children's ward needed to be improved to ensure their safety.
- There was a lack of understanding by staff around patients' ability to consent to care and treatment.
- The consultant body was cohesive, loyal to the hospital and proud to be working at the trust.
- The service to patients having a heart attack was extremely good.
- The communication with parents in the neonatal unit was very good. These included well written booklets.
- The number of one stop clinics within the out patients department was responsive to the needs of patients.

We saw several areas of outstanding practice including:

Summary of findings

- A specialist, midwife-led 'Birth reflections' clinic was provided to support women who wanted to come to terms with their birth experiences.
- Clinical reporting and scheduling system in cardiology (Intellect) has been developed locally allowing the service to be more coordinated and efficient.
- There was an excellent primary percutaneous coronary intervention (PPCI) service which provided prompt, effective treatment in line with national guidance and demonstrated good working with other providers and professionals.
- On Elsing ward we observed that the bays had been colour coded to assist patients moving around the ward and used single use knitted sensory bands were available. Holt ward had refurbished a room to 1950's décor.
- The nursing team within the emergency department demonstrated outstanding care, leadership and treatment of patients.
- The innovation around trialling new ways and models of care including medicines administration within the emergency department, as well as the vision for the service was outstanding.
- The outcomes for trauma were outstanding and the best in the region.
- The local audit programme for nurses and medical staff within the emergency department was outstanding.
- The governance risk management, learning arrangements and staff willingness to continually strive to be better for the patients in the emergency department was outstanding.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Ensure that patient acuity is properly assessed and there are adequate medical, nursing and midwifery staff to care for patients in line with national guidance.
- Follow infection control principles when cohorting patients.
- Ensure that all children's inpatient wards and units have adequate security measures in place to reduce the risk of children absconding and unauthorised adults gaining entry.
- Ensure that incidents are investigated in a timely way by trained investigators, graded, and reported in line with current national guidance.
- Ensure that the management of outliers on Cley ward are properly assessed and provided with safe care.
- Ensure that the management of referrals into the organisation reflects national guidance in order that the backlog of patients on an 18 week pathway are seen.
- Ensure that patient records are legible, accurate, complete and contemporaneous for each service user, taking into account the use of both hard and electronic records.
- Review 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms to ensure they are completed fully and in line with trust policy and national guidance.
- Review its Mental Capacity Assessment and Deprivation of Liberty Safeguarding (MCADOLS) process and the way this is documented within patients' notes – Regulation 17(2) (c).
- Ensure that staff within the radiology department have access to appropriate support, supervision and appraisal.
- Ensure that compliance to mandatory training is met and ensure consistent compliance across all clinical staff groups. Ensure that training is relevant to meet the needs of those in specific roles such as staff in the mortuary.
- Ensure that medicines are stored and administered in line with national guidance.
- Review and improve the environment of the children's emergency department to ensure that the environment is fit for purpose and safe for children to receive care.
- Review the staffing of the children's emergency department to ensure that there are sufficient numbers of registered children's nurses on duty at all times.
- Ensure that there is an increase awareness of the complexities of end of life care, including a defined strategy and vision, increased involvement and referrals to the specialist palliative care team (SPCT) and improvement in performance indicators specifically recognition of the dying patient.

In addition the trust should:

Summary of findings

- Closely monitor transfers to Mattishall ward and the environment should be improved in line with the development plan for the unit.
- The trust should reconsider the ambulatory care pathway in the acute medical unit (AMU).
- Review the availability of adequate equipment for patients to sit out of bed if clinically able to do so.
- Review the permanent clinical leadership in AMU.
- Ensure a robust process for checking of emergency equipment.
- Review its risk management and escalation policies with respect to how clinical staff raise concerns and ensure these are acted upon appropriately.
- Reduce readmission rates for children and young people with long-term conditions.
- Review the provision of information technology for community midwifery teams
- Review mechanisms for supervision and appraisal for all staff so that they are supported effectively.
- Develop an action plan to address the lack of improvement in the completion of discharge information in the specific safeguarding children paperwork for use within the maternity departments.
- Review the provision of adequate seating in the antenatal clinic.
- Reduce the number of cancelled gynaecology clinics.
- Review the ratified guidelines within the Obstetric Assessment Unit and ensure that it is located in an area where it can operate effectively.
- Put procedures in place to reduce the number of closures of the obstetric unit.
- Review the staff understanding of the vision and strategy for their areas.
- Review fluoroscopy changing areas and process to ensure patient privacy and dignity is maintained.
- Ensure that doctors within the emergency department adhere to bare below the elbow policy requirements.
- Improve the culture amongst the consultant body within the emergency department.
- Improve the culture of the organisation towards the emergency department to reduce the feeling of blame for targets not being achieved.
- Review the bed management process and site management processes within the organisation to increase capacity and flow.
- Improve systems and processes for the declaration of black alert to ensure that it contains tangible changes designed to improve the service, i.e. daily consultant or nurse led discharges.
- Review the emergency department triage process to ensure that all patients are offered pain relief where it is required.
- Review the plans for expanding the main emergency department and make a decision swiftly on the future expansion of the service.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Rating

Good



Why have we given this rating?

We rated urgent and emergency services as good overall with safety rated as requires improvement, effective and caring rated as outstanding and responsive and well led as good.

Safety of the service required improvement because the children's emergency department was not fit for purpose. The children's department has two cubicles and a treatment area within the waiting room. The main emergency department was often overcrowded, the department was originally built to see 70,000 people per year but now sees upwards of 110,000 people per year. We observed that not all doctors adhered to the elbows infection control requirements. Some triage nurses were not able to offer pain relief to people while they were waiting. There was also a shortage of registered children's nurses working within the children's emergency department. However we also found that there was a good incident reporting and learning culture within the department. There were robust safeguarding procedures in place for both adults and children. Staffing levels for both nursing and medical staff in the adult department were safe. The department had effective streaming, triage, treatment and early warning systems in place to ensure patients received safe care.

The service was outstanding for being effective because the National Audit on Severe Trauma (Trauma Audit & Research Network, TARN) for 2014 showed that the trust performs better on trauma than any other trust in the East of England on survival rates, unexpected survival rates and data submissions. The fracture neck of femur pathway between the emergency department and the orthopaedic service was outstanding due to the reconfigured pathway in place which meant that consistent care was continually provided. The department also ran a series of improvement projects, chosen by staff, who support the completion of the projects to improve safety and patient care. The department was trialling new and innovative ways of managing pain and severe pain for patients within the department. The trust's

Summary of findings

unplanned re-attendance rate within seven days at 3% was consistently below the 5% standard between January 2013 and October 2015. The department operates a range of admission avoidance programmes including diabetes, deep vein thrombosis (DVT), ulcers clinic, wound clinics and pain clinics.

The service was rated as outstanding for being caring because we consistently saw staff going above and beyond the call of duty to provide outstanding care to patients, relatives, families and other staff. All people we spoke with were overwhelmingly positive about the care and service they received. We spoke with paramedics who were all positive about the service and all expressed how they would choose to come to this emergency department over others in the area.

The service was rated as good for being responsive because there were plentiful leaflets and information sources available to support patients; the service had a dedicated area for relatives with three individual relative rooms for speaking with patients and their families and breaking bad news. Despite delays in admission to beds from the emergency department patients received care which ensured that their inpatient food, hydration and personal care needs were met. The majority of delays and breaches of the four hour target came due to a lack of bed availability, though there was still room for improvement.

The service was rated as good for being well led because the culture of the nursing workforce was outstanding with a well-established nursing team. The nursing leadership within the service, particularly at matron level, was outstanding. There was a strong culture of governance and risk management within the service. The service had a defined vision and strategy for the future, and this included the staff who contributed to the vision of the service. However there were some areas that could be improved including the attitude of medical staff and the culture of the consultant body in relation to how they work with the nursing staff and respond to the leadership team. We observed some disrespectful interactions between nursing and

Summary of findings

Medical care (including older people's care)

Requires improvement



medical staff at times though the trust did take action to improve this throughout the inspection and there was a notable improvement by the time we undertook the unannounced inspection.

We rated medical services as requiring improvement overall. Infection control processes did not always protect people from exposure to infection and the environment in Mattishall ward remained sub optimal for patient care. Training levels for safeguarding were below trust target as was other mandatory training. Patients admitted to the AMU were not all reviewed promptly and patients admitted to Mattishall ward did not all meet the referral criteria.

Nurse staffing did not reflect the acuity of patients on all wards and we raised this concern during our inspection. National guidance for staffing in relation to hyper acute stroke and non-invasive ventilation was not followed. There were large number of vacancies for acute medical consultants in the acute medical unit with the clinical director being an interim position.

Medical services were effective as care given was in line with national guidance and best practice. Staff adhered to local policy and procedures and the trust took part in numerous national and local audits. Patient outcomes were positive, the endoscopy unit was JAG accredited and risk of readmission was better than the England average. Friends and family test (FFT) scores were generally very positive for medical wards with the exception of the AMUL and staff delivered compassionate care to patients and their relatives and carers. Patients were actively involved in planning their treatment and were given options where possible.

Responsiveness required improvement because the ambulatory care service on the acute medical unit was restricted or suspended on a regular occasion due to capacity issues. There was no clear strategy for the management of the AMU or ambulatory care.

Staff were aware of the trust's vision and strategy but were unsure of the divisions or clinical strategy. Senior staff were concerned there was not a

Summary of findings

strategy for managing over the winter. There was only interim clinical leadership in a very busy and key department which had already seen a number of changes in the preceding 12 months. There was an excellent primary percutaneous coronary intervention PPCI service for patients with cardiac symptoms and enthusiastic staff and managers, passionate about improving patient care and services.

Surgery

Requires improvement



Surgery services were rated as 'requires improvement' overall. Safe, responsive and well led were all rated as requires improvement with effective and caring rated as good.

Incidents and learnings from serious incidents were not communicated in a timely manner between the Cromer and Norwich sites. Communication was identified as a concern and often changes to clinical practice at Norwich were not reflected at Cromer. Nurse staffing did not reflect the patient acuity and patient care was impacted by delays to care and medications. There were 33 vacancies across the service, registered nurse hours were frequently replaced by healthcare assistant hours. Staff reported being discouraged from using the electronic incident system to raise concerns about staffing shortages due to the time taken to investigate these incidents.

Five of the nine surgical specialties did not meet the 90% standard of the proportion of patients waiting less than 18 weeks from referral to treatment. The proportion of cancelled operations which were not rebooked within 28 days had been worse than the England average since April 2013. The service had opened the day case theatre on Saturdays to elective cases to meet the needs of local people and a new Vanguard theatre was under installation to reduce the number of patients awaiting surgery. Cromer hospital provided numerous one stop clinics for cataract surgery and urology. This meant that patient could be seen and treated in one appointment to improve patient experience and reduce delays.

Ward areas were visibly clean, with appropriate equipment and facilities for hygiene and infection control, but hand washing and decontamination processes were found to be inconsistent.

Summary of findings

Equipment was available to staff and had been serviced and checked in line with policy. Medicines were stored securely and appropriately although on the surgical assessment unit the ambient temperature of the room where medications were stored had exceeded the temperature recommended but no actions had been taken to ensure the efficacy of the medications.

Multidisciplinary attendance on ward rounds and ward meetings was generally good. Three wards had access to a dedicated pharmacy lead and staff were able to access specialist support from a pain management team and a safeguarding lead. Induction and competency assessments were in place for bank and agency staff and there was an attempt to use regular agency staff. However, locum and agency staff did not have access to the computer system and could not request or review information as a result.

The majority of patients and relatives said that nursing staff were caring and helpful and that staff treated patients with dignity and respect. However, patient feedback on their understanding and involvement in their care was mixed. Handling of patient complaints was not consistent across all areas.

There had been a change in the leadership team and whilst some staff felt that the culture had started to improve others reflected and staff morale was still low within the surgery division with staffing and clinical pressure a contributing factor. Local leadership was good however visibility of the senior team across all areas was varied and responses to issues highlighted were not actioned or responded to in a timely manner. There was a lack of managerial support for senior staff at Cromer hospital.

Critical care

Good



The safety of critical care at Norfolk and Norwich University Hospital required improvement. The effective, caring, responsive and well-led domains were good.

Patients and their relatives were treated with respect and dignity by competent staff who were passionate and provided treatment in line with national standards and benchmarks. Staff were proactive in reporting incidents and senior staff on

Summary of findings

the unit conducted thorough investigations that had led to improvements in practice. The critical care complex (CCC) was clean and well-maintained and staff demonstrated an acute understanding of how to provide person-centred care that met the treatment needs of individuals and also considered their wellbeing and social needs.

The mortality rate of the CCC was consistently lower than the national average for similar units, at 15%. Staff used care bundles appropriately and audited these regularly. Multidisciplinary input into patient treatment plans was available but significant short staffing meant that the unit did not have a full time pharmacist and that the presence of physiotherapists and microbiologists on ward rounds was inconsistent.

Medical staffing out of hours did not meet the requirements of the Intensive Care Society (ICS). Nurse staffing levels did not meet the recommended requirements of the Royal College of Nursing (RCN) or the Faculty of Intensive Care Medicine (FICM), with each shift regularly short of up to four nurses. A supernumerary senior nurse coordinator was not always available out of hours on the intensive care unit.

In 2014/15, 63.6% of patients experienced a delayed discharge of four hours or more. Introduction of a more robust escalation process had started to reduce delayed discharges through more effective clinical and operational governance. Staff were encouraged to contribute to the development and improvement of the service.

Staff were not always listened to or engaged with appropriately by the trust's senior leadership team when they had escalated areas of concern or risk. In the year prior to our inspection the unit had experienced significant disruption to its staff team, including the departure of two matrons. We found that staff had established a coherent, mutually supportive working environment and culture and were positive about the changes that had been implemented by a new matron and operational manager.

Maternity and gynaecology

Requires improvement



Maternity and gynaecology services were rated as requires improvement overall. Investigation of incidents was often delayed due to the reliance on

Summary of findings

clinical staff to complete initial investigations with no time allocated away from their clinical duties, and the small number of staff trained to complete root cause analysis (RCA).

The maternity service was staffed to provide a ratio of one midwife to every thirty births. However, we found that the service provided a real time ratio of one whole time equivalent midwife to 34 births, which was significantly below the national standard, due to sickness and absence. Consultant obstetric cover in the delivery suite was significantly less than (worse) the Royal College of Obstetrics and gynaecology of 198 hours a week for a unit of this size.

Emergency drugs were not stored securely and were therefore at risk of theft or tampering.

Appraisal rates were low for both nursing and midwifery staff and administrative and clerical staff. Community midwives did not have access to individual information technology.

There were 21 closures of the maternity unit between October 2014 and September 2015.

The obstetric assessment unit had been operating without ratified guidelines, with minimum staff and in a location which caused disturbance to other patients and was remote from the women who were waiting to be treated.

The vision of the maternity service was not known by staff of any grade and not visible or embedded in practice.

The normal birth, overall caesarean section and instrumental delivery rates were all better than the national average.

There was an anaesthetic consultant on call for the maternity service 24 hours a day, seven days a week providing epidurals when requested.

Women were very positive about the care they received and felt they were supported to make informed choices.

The maternity service and the Maternity Services Liaison Committee (MSLC) worked well together to improve care for women.

**Services for
children and
young
people**

Requires improvement



Processes to reduce the spread of infections and protect people from harmful waste were not always

Summary of findings

followed. Security was not adequate in the children's day ward and Lion ward, where there was no secure entry and children could reach door handles.

Resuscitation trolleys and equipment were not secure and emergency drugs were accessible on the top of trolleys. Resuscitation trolleys were not checked consistently according to the schedules set by the trust and there was no grab bag of emergency equipment in all areas where children were treated. Checks of controlled drugs were not consistent on Buxton ward.

Compliance to safeguarding children training was not consistent for all staff working within the children and young people's service. There was no mental health nurse provision for mentally unwell children admitted to the service, and few staff had any mental health competencies to care appropriately for these children. Mandatory training compliance was not consistent.

Staffing levels in nursing were consistently below the requirements of the service, due to high levels of maternity and sickness leave, meaning that patients may be at risk of not receiving appropriate care at the time they required it.

Readmission rates for children with long-term conditions were worse than the England average, meaning that care provided may not be adequate to keep conditions controlled.

Referral to treatment times did not always meet the 18-week standard that all patients have the right to expect.

Children with complex needs did not always receive care that suited their needs in the best way.

Children were admitted to adult wards where their needs may not be met.

Escalation and action of clinical governance issues were not robust.

End of life care

Requires improvement



End of life services at Norfolk and Norwich University Hospital required improvement overall. Safety, effectiveness, responsiveness and well led were all rated as requires improvement. Caring was rated as good for the service.

'Do not attempt cardio-pulmonary resuscitation' (DNACPR) forms were not always completed fully or accurately. The trusts DNACPR forms did not

Summary of findings

conform to national standards. No standardised documentation pathway had fully replaced the Liverpool Care Pathway (LCP) which had been phased out. The trust was using care-rounding forms to assess patients hourly for pain, comfort and hydration, and other key aspects of care. There was an incident reporting system in place however, this did not specifically capture incidents concerning patients at the end of their lives. The trust did not have systems in place to make effective assessment of the quality of end of life care. The trust scored significantly worse than the national average in the latest national care of the dying audit, meeting only 47% of the key performance indicators. There was no on-site seven-day specialist palliative care service at the trust. Out-of-hours staff across the trust were unsure of who to contact should advice be needed. The specialist palliative care team (SPCT) had the vision to create a seven-day service however the current staffing was not sufficient to support this. Patients at the end of life and their relatives were cared for with respect and compassion and in a way that considered their dignity.

Outpatients and diagnostic imaging

Requires improvement



Outpatient and diagnostic services were rated as requires improvement with caring, and well led rated as good, but safety and responsive were rated as requires improvement, which gives a rating of requires improvement overall. Incident reporting and correct identification of harm were not robust in either outpatients or radiology services. There had been three ophthalmic never events in the trust in last three years and two in dermatology in the last two years. The consistency of incident reporting was not robust; there was a limited number of staff trained to undertake root cause analysis; and reporting responsibility sat with senior staff members, with little individual feedback or learning. Incidents were not always classified correctly which resulted in under-reporting. There had been three dermatology incidents that we raised with the trust as potentially

Summary of findings

meeting the never event criteria. The trust held a serious incident meeting at the end of November 2015 to review the incidents and two were raised retrospectively as never events.

The trust was not meeting two of its referral to treatment targets for cancer patients.

The Cromer site was potentially underutilised given the appointment waiting lists at the main Norwich site.

There was effective patient focused care provided by 'one-stop clinics' and innovative nurse led clinics. The venous-thromboembolism (VTE) clinic had been recognised nationally winning the British Nursing Journal award for 2015.

Patients and relatives gave high praise for the care received within the trust. Clinics collected patient feedback to improve services. Initiatives were trialled, audited and monitored to improve the safety and experience of patients.

It was evident that there was a strong teamwork ethos with a large number of staff employed for many years within the trust. Staff were very passionate and proud of the services they offered to patients.

Norfolk and Norwich University Hospital

Detailed findings

Services we looked at

Urgent & emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and Gynaecology; Services for children and young people; End of life care; Outpatients & Diagnostic Imaging

Detailed findings

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Background to Norfolk and Norwich University Hospital

The Norfolk and Norwich University Hospital is an established 1237 bedded NHS Foundation Trust which provides acute hospital care for a tertiary catchment area of up to 822,500 people. Acute hospital care means specialist care for patients who need treatment for serious conditions that cannot be dealt with by health service staff working in the community.

The Trust provides a full range of acute clinical services, including more specialist services such as oncology and radiotherapy, neonatology, orthopaedics, plastic surgery, ophthalmology, rheumatology, paediatric medicine and surgery.

The status of Foundation trust was achieved in May 2008. The Trust is one of the largest teaching hospitals in the country. The Trust operates from a large purpose built site on the edge of Norwich and from a smaller satellite at Cromer in North Norfolk as well as operating a reablement unit, named the Henderson unit, at the Jubilee Hospital.

The majority of patients live in Norfolk, North Suffolk and Waveney, however tertiary services are provided beyond

these boundaries. The Trust has the largest catchment population of any acute hospital in the East of England. The main University hospital is strategically placed adjacent to Norwich Research Park and the A47. It offers a high quality environment with facilities constructed and operated through the PFI initiative and was completed in late 2001.

This trust is registered for the activities of:-

Treatment of disease disorder or injury.

Assessment or medical treatment of persons detained under the Mental Health Act 1983.

Surgical procedures.

Diagnostic or screening procedures.

Management of supply of blood and blood derived products etc.

Maternity and midwife services

Termination of pregnancies.

Family planning.

Our inspection team

Our inspection team was led by:

Chair: Dr Sean O'Kelly, Medical Director of University Hospitals Bristol NHS Foundation Trust

Head of Hospital Inspections: Fiona Allinson, Head of Hospital inspections, Care Quality Commission

Detailed findings

The team included 17 CQC inspectors and a variety of specialists including a clinical fellow, a safeguarding specialist, a pharmacist, two medical consultants, a consultant in emergency medicine, a consultant obstetrician, a consultant gynaecologist, an intensive care consultant, a consultant paediatrician, a junior

doctor, ten nurses at a variety of levels across the core service specialities and two experts by experience. (Experts by experience have personal experience of using or caring for someone who uses the type of service that we were inspecting.)

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection took place between 10 and 13 November 2015.

Before visiting, we reviewed a range of information we held, and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG); Monitor; NHS England; Health Education East of England (HEE); General Medical Council (GMC); Nursing and Midwifery Council (NMC); Royal College of Nursing (RCN); College of Emergency Medicine; Royal College of Anaesthetists; Norfolk Health Overview and Scrutiny Committee (NHOSC) and the local Healthwatch.

We held two listening events, one on 4 November 2015 in Cromer and one on 10th November in Norwich, when

people shared their views and experiences of both hospital sites. Some people who were unable to attend the listening event shared their experiences with us via email or by telephone.

We carried out an announced inspection visit between 10 and 13 November 2015. We carried out unannounced inspections at the Norfolk and Norwich Hospital on 20 and 25 November and at the Henderson unit on 25 November 2015.

We spoke with a range of staff in the hospital, including nurses, junior doctors, consultants, administrative and clerical staff, radiologists, radiographers and pharmacists.

We talked with patients and staff from all the ward areas, operating theatres and outpatient services. We observed how people were being cared for, talked with carers and/or relatives and reviewed patients' records of personal care and treatment.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Norfolk and Norwich University Hospitals NHS Foundation Trust.

Facts and data about Norfolk and Norwich University Hospital

Norfolk and Norwich University Hospitals NHS Foundation Trust has two main locations

- Norfolk and Norwich University Hospital, a large acute hospital comprising all acute services.
- Cromer Hospital which offers surgical and outpatients' services.

In addition there is the Henderson unit which opened in December 2014 and provides a 24 bed health and social

care reablement unit. The unit provides an intermediate service, a "stepping stone" between hospital admission and returning home, and has direct links with community services.

The trust primarily serves a population of 822,500 people within the local catchment area in Norfolk and Norwich, as well as patients from further afield for the specialist services that it provides.

Detailed findings

The trust's main commissioning CCG is NHS Norwich Clinical Commissioning Group.

• **Beds:** 1,237

- 1,094 General and acute
- 65 Maternity
- 20 Adult Critical care of which ITU - 10 beds

HDU - 10 beds

- Neonatal Intensive Care - 9 beds
- Neonatal High Dependency – 6 beds
- Paediatric HDU – 4 beds

• **Staff:** 5,969

- 866 Medical (against an establishment of 902)
- 1,877 Nursing (against an establishment of 2,189)
- 3,226 Other (against an establishment of 3,839)

• **Revenue:** £515m

• **Full Cost:** £525m

• **Surplus (deficit):** (£10m)

Activity summary (Acute) 2014/15

Inpatient admissions 210,438

Outpatient (total attendances) 738,581

Accident & Emergency 111,731

(attendances)

During 2014 there were 738,581 outpatient appointments, of which 32% were first attendances and 68% were follow up appointments.

In the latest CQC Intelligent Monitoring report (May 2015), the trust had nine risks and one elevated risk. The priority banding for inspection for this trust was 4, and their percentage risk score was 4.2%.

The risks identified were as follows:

- Never Event incidence
- Potential under-reporting of patient safety incidents resulting in death or severe harm
- Composite of knee related PROMS indicators
- Composite indicator: A&E waiting times more than 4 hours
- The number of patients not treated within 28 days of last minute cancellation due to non-clinical reason
- Monitor - Governance risk rating
- Proportion of patients spending more than four hours in Type 1 only A&E departments from arrival to discharge, transfer or admission
- Ratio of charge nurse/ ward sister (band 7) to band 5/6 nurses
- PROMs Oxford score: knee replacement (PRIMARY)

The elevated risk was:

All cancers: 62 day wait for first treatment from urgent GP referral

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Outstanding	Outstanding	Good	Good	Good
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Good	Good	Good	Good	Good
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	N/A	Good	Requires improvement	Good	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Urgent and emergency services

Safe	Requires improvement	
Effective	Outstanding	
Caring	Outstanding	
Responsive	Good	
Well-led	Good	
Overall	Good	

Information about the service

The emergency department (ED) at Norfolk and Norwich University Hospital provides a 24-hour, seven day a week service to the local area. The department was originally built for 60,000 attendances however between April 2014 and March 2015 the trust had 111,731 emergency department attendances. 19% of emergency department attendances between April 2015 and July 2015 were children aged zero to 16 years old, a total of 21,527.

Between April 2015 and June 2015 32,311 (28%) attendances resulted in an admission, which is higher than the England average of 22%. The proportion of attendances resulting in admission at this trust has been higher than the England average since 2013/14.

The trust had a single point of access reception which triaged patients into the urgent care centre (UCC) operated by a separate provider. This had reduced the pressure on ED as there were approximately 30 patients each day diverted to UCC.

In 2013/14, 37,030 attendances arrived by ambulance and/or helicopter, out of a total of 106,955. In April 2015, 2.6% of persons attending A&E left without being seen. The trust's unplanned re-attendance rate to A&E performance met the standard for the majority of the period between January 2013 and May 2015.

Patients presented to the department either by walking in via the reception or arriving by road or air ambulance. The

department had facilities for assessment, treatment of minor and major injuries, a review area which consisted of three bays for patients awaiting transfer to the ward, a resuscitation area and a separate children's area.

During our inspection we observed care in the clinical environment and we spoke with 42 members of staff including doctors, nurses, support staff and managers, 23 patients and six relatives of patients or members of the public, and 14 visiting ambulance staff who brought patients into the department. We also met with the leaders of the service and examined the records of 26 patients who used the service and 100 individual pathways to assess how the emergency department performed against the quality standards set by the college of emergency medicine to achieve the four hour target.

Urgent and emergency services

Summary of findings

We rated urgent and emergency services as good overall with safety rated as requires improvement, effective and caring rated as outstanding and responsive and well led as good.

Safety of the service required improvement because the children's emergency department was not fit for purpose. The children's department had two cubicles and a treatment area within the waiting room. The main emergency department was often overcrowded; the department was originally built to see 70,000 people per year but now sees upwards of 110,000 people per year. We observed that not all doctors adhered to the elbows infection control requirements. Some triage nurses were not able to offer pain relief to people while they were waiting. There was also a shortage of registered children's nurses working within the children's emergency department. However we also found that there was a good incident reporting and learning culture within the department. There were robust safeguarding procedures in place for both adults and children. Staffing levels for both nursing and medical staff in the adult department were safe. The department had effective streaming, triage, treatment and early warning systems in place to ensure patients received safe care.

The service was rated outstanding for being effective because the National Audit on Severe Trauma (Trauma Audit & Research Network, TARN) for 2014 showed that the trust performed better on trauma than any other trust in the East of England on survival rates, unexpected survival rates and data submissions. The fracture neck of femur pathway between the emergency department and the orthopaedic service was outstanding due to the reconfigured pathway in place which meant that consistent care was continually provided. The department also ran a series of improvement projects, chosen by staff, who support the completion of the projects to improve safety and patient care. The department was trialling new and innovative ways of managing pain and severe pain for patients within the department. The trust's unplanned re-attendance rate within seven days at 3% was consistently below the 5% standard between January

2013 and October 2015. The department operates a range of admission avoidance programmes including diabetes, deep vein thrombosis (DVT), ulcers clinic, wound clinics and pain clinics.

The service was rated as outstanding for being caring because we consistently saw staff going above and beyond the call of duty to provide outstanding care to patients, relatives, families and other staff. All people we spoke with were overwhelmingly positive about the care and service they received. We spoke with paramedics who were all positive about the service and all expressed how they would choose to come to this emergency department over others in the area.

The service was rated as good for being responsive because there were plentiful leaflets and information sources available to support patients; the service had a dedicated area for relatives with three individual relative rooms for speaking with patients and their families and breaking bad news. Despite delays in admission to beds from the emergency department patients received care which ensured that their inpatient food, hydration and personal care needs were met. The majority of delays and breaches of the four hour target came down to a lack of bed availability, though there was still room for improvement.

The service was rated as good for being well led because the culture of the nursing workforce was outstanding with a well-established nursing team. The nursing leadership within the service, particularly at matron level, was outstanding. There was a strong culture of governance and risk management within the service. The service had a defined vision and strategy for the future, and this included the staff who contributed to the vision of the service. However there were some areas that could be improved including the attitude of medical staff and the culture of the consultant body in relation to how they work with the nursing staff and respond to the leadership team. We observed some disrespectful interactions between nursing and medical staff at times though the trust did take action to improve this throughout the inspection and there was a notable improvement by the time we undertook the unannounced inspection.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement



We rated urgent and emergency services as requires improvement for being safe because:

- The children's emergency department was not fit for purpose. The children's department has two cubicles and a treatment area within the waiting room. The waiting area was very small and was not able to accommodate the volume of children and parents attending. Within the two cubicles there was only one oxygen flow and one air flow port available, this meant that should more than one child require a nebulizer or oxygen at any one time this would not be immediately possible.
- The environment was often overcrowded with limited space to place all the people who attended the department. The department was originally built to see 70,000 people per year but now sees upwards of 110,000 people per year.
- Throughout the inspection we observed that not all doctors adhered to the elbows infection control requirements.
- Some triage nurses were not able to offer pain relief to people while they were waiting. This meant that people did not always receive consistent care at triage when pain relief was required.
- There was a shortage of registered children's nurses working within the children's emergency department.
- The medical handovers we observed were short and did not provide a level of detail we expected from a medical handover within an emergency department. Feedback provided raised the points about medical handovers not being as detailed, robust or effective as they could be.

However we also found:

- There was a good incident reporting and learning culture within the department.
- There were robust safeguarding procedures in place for both adults and children.
- Staffing levels for both nursing and medical staff in the adult department were safe.
- The department had effective streaming, triage, treatment and early warning systems in place to ensure patients received safe care.

- Staff were aware of requirements related to major incidents and what they would need to do in the event of an emergency.
- Whilst there were recorded delays in ambulance handovers the trust this was linked to the capacity and demand pressures within the hospital. The department was achieving the 15 minute triage and assessment and 60 minute treatment times.

Incidents

- The service followed the trusts incident reporting policy and has reported 334 incidents between 1 March and 31 August 2015.
- The incidents reported, in the majority, resulted in no or low harm for impact with the top reported incidents being low staffing levels, aggressive behaviour from patients, clinical assessment and observations and handover concerns. The most reported incident was for patients who were identified as having a community acquired or pre-existing pressure ulcer whilst in the department.
- The trust reported three serious incidents between August 2014 and July 2015. One of the serious incidents was an unexpected death, and the other two were diagnostic incidents.
- The service has no reported never events. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- There were no pressure ulcers, no falls and one catheter urinary tract infection recorded via the Patient Safety Thermometer between July 2014 and July 2015.
- The department held monthly meetings which discussed all deaths that occurred within the department, reviewed the causes and identified any learning points for improvement. We reviewed the minutes of the last six meetings which confirmed what we were told.
- Information on incidents, learning, key messages and mortality and morbidity was also displayed on the staff notice board for information and awareness.
- We reviewed the log kept by the department on all events where duty of candour was used following a reportable event. The department maintained a log of the incident, who spoke with the person involved the message given, when the investigation will be provided

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to them and who would be contacting them to provide further feedback. The service also reported where duty of candour had been used at their monthly governance meetings.

- Medical and nursing staff we spoke with were aware of the requirements of duty of candour and informed us of the process to escalate where they believe it is required at the time of reporting the incident.

Cleanliness, infection control and hygiene

- In the emergency department 66% of medical and dental staff and 83% of nursing staff had completed training for infection control, compared to the trust target of 75%.
- There have been no reported cases of methicillin-resistant *Staphylococcus aureus* (MRSA) or *Clostridium difficile* (C.diff).
- Throughout the inspection we observed the nursing and support staff adopt good hand hygiene techniques with frequent hand washing and use of alcohol gels. Staff used the personal protective equipment including gloves, aprons and masks available appropriately.
- Throughout the inspection there were three doctors who we observed repeatedly did not follow the bare below the elbows requirement by wearing long sleeved shirts, which were not rolled up above their elbows, wrist watches and ties which were not tucked into their shirts.
- We spoke with the individuals, as did the nursing staff, to request they adhere to the 'bare below the elbows' policy however we observed soon after that they had rolled their sleeves back down or put their watch back on. We escalated this to the clinical leads and executive team for their awareness and action as appropriate.

Environment and equipment

- We examined the records of the resuscitation equipment which was stored throughout the department and found that it had been regularly checked consistently over the previous three months. We examined one of the trolleys in detail and found that the trolley was fully stocked and ready for use if required.
- We examined the anaphylaxis boxes and blood glucose boxes and saw that these had been checked daily as required. The blood sugar boxes contained evidence of when the machine was last calibrated to ensure it was accurate in giving results.

- We examined a selection of 25 items of equipment throughout the department including a resuscitaires, blood pressure machines and cardiac monitors and found that these had all been serviced, maintained and tested for electrical safety.
- Within the main emergency department the curtains were disposable and were dated when they were last changed. The trust policy is that these are changed as minimum every three months or when required. We observed that all the curtains we saw were within the three month time frame.
- Within the minors department, which is a separate area to the main emergency department, this area did not have disposable curtains. These curtains were not dated with when they were last changed, we asked the cleaning staff for the records of when these were last changed however not records were made available to us. The matron informed us that there were plans to change these curtains to the disposable curtains.
- The environment was often overcrowded with limited space to place all the people who attended the department. The service had reorganised and redesigned the department, so far as possible to accommodate the increased numbers of attendances to make it safe however they were challenged. The department was originally built to see 70,000 people per year but now sees upwards of 110,000 people per year.
- There were plans in place to expand the current department, which had been designed by staff, however the plans had been stopped prior to our inspection. The chief executive informed us that they were considering all options for a solution to be cost effective and provide a department which will sustain continued increases in patient numbers before commencing the build.
- The children's emergency department was not fit for purpose. The children's department was within the main emergency department. The children's department has two cubicles and a treatment area within the waiting room. The design meant that privacy of the child or parents was not possible as the neighbouring bay and the waiting room could hear the consultation.
- The waiting area was very small and was not able to accommodate the volume of children and parents attending which meant that there were occasionally queues forming in the corridor to get into the waiting room.

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- Within the two cubicles there was only one oxygen flow and one air flow port available, this meant that should more than one child require a nebulizer or oxygen at any one time this would not be immediately possible.
- There was no high dependency area within the children's department or resuscitation trolley. The staff informed us of the procedure to take the child down the corridor immediately to the resuscitation department should support be required. However due to crowding at peak times they would be challenged in getting the trolley out of the room, and whilst we were assured that staff were vigilant they also were concerned for the safety of children who used the department.
- The risks associated with the environment of the children's emergency department was recognised by the service and by the trust as it was on their risk register, and the chief executive informed us that the children's department would be redesigned as part of the larger rebuild project. However we informed the chief executive that the risks to children who may deteriorate in the department remains high until a solution can be found.
- Emergency medicines were available for use and there was evidence that these were regularly checked. Controlled drugs are medicines which are stored in a special cupboard and their use recorded in a special register, and when we examined the register and stock we saw that the stock was correct and controlled drugs were securely stored.
- While some triage nurses, who were of a senior enough grade, were able to offer pain relief to people while they were waiting, others had to contact the department which the person was transferred to, or call a colleague to help. This meant that people did not always receive consistent care at triage when pain relief was required.

Records

- Health record keeping training is provided to all staff within the department. Of the staff in the department 82% of nursing staff and 77% of medical staff and 100% of AHPs had received this training.
- We examined the records of 26 patients who were in the department. We observed that the records were detailed and clear about the plan and pathway of care and when the next steps in care were required, for example 'plan for x-ray and then to review pain score to ensure pain relief given prior to x-ray'.
- When a patient was to be admitted to the hospital but a bed was not available for them due to capacity issues the emergency department were required to provide those patients inpatient care. We observed that at the four hour mark if a bed was not available for the patient to go to a ward the patient was transferred onto a hospital bed and their risk assessments for pressure ulcers, nutrition and hydration, falls and hygiene needs were completed. We also observed in the six records of patients who were inpatients we looked at received regularly recorded care rounds to meet their needs.

Safeguarding

- All nursing staff and 74% of medical staff had completed statutory training on safeguarding children (level 1).
- For level 3 safeguarding children training 69% of nursing staff and 53% of medical staff had completed the statutory training.
- For safeguarding adults 59% of medical staff, 90% of nursing staff and 100% of allied health professionals (AHPs) had received training.

Medicines

- Of the staff in the department 74% of medical staff and 85% of nursing staff had completed the training on medicines management.
- Specialist pharmacists, including independent prescribers and a toxicology specialist, were available to visit the department between 8am and 8pm on weekdays and on call out of hours.
- We spoke with a member of pharmacy staff who told us that this service was being extended following a successful pilot and there will be pharmacists based in the department seven days a week. This pharmacist would see people with medicine related symptoms and carry out medicines reconciliation for those being admitted to the hospital to make sure that the prescription is completed and that medicines are available when needed.
- The pharmacy team provided a stock top up service to the department so that people have access to medicines when they needed them.
- Medicines were stored securely to prevent them being tampered with, including medicines that patients had brought with them. An automated dispensing machine was in use to improve the secure storage of regularly used medicines.

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- Staff we spoke with throughout the department were clear on the requirements for safeguarding adults and children, and produced a booklet which they carry with them to refer to if they had any queries.
- Staff could articulate for both adult and younger females the requirements to report any female genital mutilation. One nurse was also able to describe to us information shared where the department had reported a case to the police and this good practice had been shared positively amongst the team.
- The department reported incidents through the online reporting form for all safeguarding adult referrals made, and audited their records to ensure that the safeguarding proforma was completed during the patient's time within the department. Learning around safeguarding was shared at the monthly governance meetings, staff meetings and also through the staff notice boards.
- The children's department had clear and robust arrangements for the safeguarding of children, which we observed during the inspection. The named safeguarding children's attended the department regularly and spoke to us about their engagement with the service. During the inspection there was a difficult case involving the death of a child which was done using the appropriate child death review protocols and implemented the safeguarding requirements related to this. We were assured that the staff were fully aware of what they needed to do in that situation.
- The children's department had recently been reviewed by the safeguarding children's board and a report of their findings also praised the team for their vigilance with safeguarding children.

Mandatory training

- The trust set an internal target of 85% completion for all staff groups for mandatory training in November 2015. Mandatory training completion for emergency department staff was 81% overall.
- For the Emergency Department the overall training completion rate was 70% on the data provided, however updated data provided to us by the matron and clinical lead during the inspection showed that this had improved to an overall rate of 78% but there were areas which required improvement.
- The staff expressed to us that at times of significantly high demand it was difficult to attend training. Also that

because training was undertaken at set times in the day not all trainers were flexible in undertaking training in the emergency department at suitable times when more staff could attend.

- We were informed that other staff were willing to be flexible to support training needs, including the emergency planning lead who attended to provide bespoke training at known quieter times to get staff trained, which the department appreciated.
- Training completion rates for equality and diversity were 74% though only 46% of medical staff had completed it.
- Fire safety was attended by 86% of medical staff and 87% of nursing staff. Health and safety was attended by 82% of nursing staff, 87% of medical staff and 100% of allied health professionals (AHPs). Information governance training was attended by 39% of medical staff, 76% of nursing staff and 0% of AHPs.
- Moving and handling training, to safely move patients, was provided to 83% of medical staff, 82% of AHPs and 77% of nursing staff.
- Prevention and management of aggression training was provided to 12% of medical staff, 71% of nurses and 64% of AHPs.
- VTE training had been received by 85% of medical staff and 71% of nursing staff in the department.

Assessing and responding to patient risk

- Within the department 57% of medical staff and 82% of nursing staff had received advanced life support training for adults, and 56% of medical staff and 67% of nursing staff had received paediatric life support training.
- Between July 2014 and April 2015, the median time to initial assessment was around three minutes, which is better than the England average of five minutes.
- In the same period, the time to treatment was on average 75 minutes, which is longer than the both standard of 60 minutes and the England average of 55 minutes.
- We reviewed this through the inspection and discussed these indicators with the matron and clinical lead who provided us with evidence up to October 2015, which demonstrated that there had been significant improvement in 60 minute treatment times with the average falling to 50 minutes in October 2015. They were using these numbers to benchmark the team and ensure that better flow was maintained.
- We reviewed 10 pathways over the course of the four day inspection to determine at various times of the day

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if time to initial assessment was within 15 minutes, time to treatment was within 60 minutes and a decision to discharge or admit a patient was given within three hours. For the 100 pathways 100% of people were assessed within 15 minutes, 97% were treated within 60 minutes and 100% were treated within 70 minutes, and a decision to admit or discharge was given within three hours to 100% of cases. This meant that the process being followed by the department to assess and treat patients was working effectively.

- Over the winter period (November 2014 to March 2015) there were 1,591 ambulance hand-overs delayed for over 30 minutes at this trust, putting the trust in the top third of all trusts in England for numbers of delayed handovers.
- The data demonstrated that the trust received more ambulances per day than any other hospital in the East of England, and more than three times the number of any ambulances compared to the other hospitals in Norfolk, which was an anomaly. The trust on average received 160-190 ambulances per day.
- We reviewed this concern as part of the inspection and found that in response to the issue the department had changed their ambulance handover process. There were two coordinators in charge of flow within the department on each shift, the main coordinator oversees the entire department, and the second looked specifically at patient intake and flow to the department and their pathways. This second coordinator role was put in following handover time concerns and as a result the service has significantly reduced handover time delays within 30 minutes. The latest report we saw showed that over the month had reduced from an average of 300 per month to an average of 50 on a quiet month and 100 on a busy attendance month between May and October 2015.
- The matron had plans to reduce this further and the chief Operating Officer and Chief Executive were in discussion with the ambulance trust about the number of ambulances who attend in the same hour to try and coordinate a better flow for the ambulances to share the workload to other hospitals in Norfolk.
- The trust performed 'about the same' as other trusts in the 2014 CQC A&E Survey questions relating to Safety. Lowest scores were for questions relating to the length

of time waiting for an examination by a doctor (6.7 out of 10) and the length of time waiting to speak to a doctor initially (7.0 out of 10). Scores for wait times with ambulance crews (8.5 out of 10).

- Between August 2014 and July 2015 there were 507 black breaches at this trust, where handovers from ambulance arrival to the patient being offloaded to the Emergency Department took longer than 60 minutes. The largest number of black breaches (116) happened in December 2014.
- Reasons for the breaches during December 2014 included an infection control incident which led to the closure of the minor injury unit and also a prolonged period of black alert (with an exceptionally high number of patients) during the final week of 2014.
- The most common reason given was lack of capacity, with 44% of black breaches occurring for this reason. A further 37% of black breaches were due to a high number of ambulances and lack of capacity.
- We reviewed this concern as part of the inspection and found that the problem was due to the availability of space within the department. Each morning several patients were being treated as inpatients in the department and the department was at maximum physical capacity which meant that patients were being treated by the team in the ambulance bay. We found that the care of these patients under the RAT team was safe and well managed, however due to not being able to release the ambulance the trust's performance on this standard was much lower than expected.
- The department had a clear process and flow chart for streaming, triage, minors, majors and ambulance, they also had a stream to send patients to the urgent care centre where they could be seen by the GPs. This service within the urgent care centre is provided by the community trust. We did not identify any concerns regarding the flow and streaming of patients through the service, though no consideration had been considered to diverting some ambulances with patients to the urgent care centre where the patient only needed to see a GP.
- The department had a senior nurse led rapid assessment and treat (RAT) process, with a registrar, which worked for 18 hours of each day and flexibly could cover the remaining six hours if required. The RAT team reviewed all patients who came into the

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department by ambulance and fed back to the receiving coordinator what the plan of care would be and what was required and commence the treatment plan at that point.

- The department had an escalation plan internally within the service as well as outwardly into the trust. The internal plan was triggered by the number of patients within the department or the number of ambulances attending, and when the department did not have capacity to place patients they used their escalation to overflow into the corridor area. The corridor area contained a triage bay where the RAT team would assess patients and the corridor was always staffed by a senior band six nurse with a band five support; these nurses had access to a foundation year doctor if additional support was required.
- We reviewed the staffing and clinical arrangements for the overflow area, and whilst staff felt this was not ideal for the patients, they did manage this safely and were very efficiently using their escalation protocol to keep patients safe within the department.
- We examined 26 patient records including their observations and neuro observations charts where required. Of the 26 we examined all observations were undertaken in the time frame specified by the medical team.
- The department used the National Early Warning Score (NEWS), which is the standardised assessment of acute illness severity in the NHS. We examined the scores calculated in the 26 sets of patient records we examined and found that they had all been calculated correctly.
- Where a patient was beginning to score on the NEWS and required medical intervention the doctor in charge would be informed and the RAT team would also provide support where required.
- The department's quarterly observation audit up to October 2015 showed that 100% of notes audited had completed observations.

Nursing staffing

- The department had a vacancy rate of 6.58 at the time of the inspection. The turnover rate for staff in the department was 0.94%.
- Sickness rates were higher than the trust expected 5% at 6.19%; the majority of the sickness was attributed to long term sickness which was covered by long term booked agency staff.

- The ideal staff ratio for registered nurses on shift was for 24 on the early, 24 on the late and 18 on the night shift. The fill rates for those shifts ranged from 50% and 110% during August, September and October and during the first week of November. All vacant shifts for healthcare assistants had been filled at the time of the inspection with new staff due to start within the three months after our inspection.
- The ideal staff ratio for healthcare assistants on shift was for eight on the early, eight on the late and five on the night shift. The fill rates for those shifts ranged from 83% and 117% during August, September and October and during the first week of November.
- There was a shortage of registered children's nurses on duty. The ideal ratio set by the department was for one registered children's nurse on duty for an early shift, one for a late shift and one for a night shift. The department saw 21,527 in 2014/15 and one registered children's nurse on duty per shift would not be sufficient.
- The fill rates for the shifts of children's nurses was also low with 30-40% of shifts each month being short of registered children's staff.
- When the department anticipated higher than average attendances or required additional staff they extended their shift numbers to meet requirements based on dependency using the recognised BEST tool from the college of emergency medicine. This was evidenced through review of the rotas where some shifts were staffed at 118% during busy periods.
- The skill mix within the department was challenging at times for the department to manage, however the matron tried organise the shifts with experienced staff working at all times to support the more junior staff, however they acknowledged that striking this balance was challenging at times.
- The department used agency and bank staff frequently to provide cover for vacant shifts. The department tried to fill shifts through bank staff first but then utilised agency staff from a preferred agency.
- The staff from the agency and the bank went through local induction and trust training to provide a regular service. We observed training records for the agency and bank staff on duty which confirmed that they had been inducted, trained and cleared as competent to administer medication.

Medical staffing

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- The department had a clinical lead consultant as well as a clinical director linked to the department. The department has consultant grade staff, including one with a dual registration for adults and children's emergency care. The department had recently employed a full time paediatric consultant doctor in paediatric emergency medicine which would enable them to provide a seven day service for paediatric emergency medical staff. The service currently only covers four days per week through the department and the other days are supported through the paediatric inpatient department.
- The department has seven consultants currently employed by utilise locum to increase the numbers to fill 10 spaces on the medical rota. This provides sufficient coverage to the emergency department for 16 hours per day with the remaining eight hours being covered through an on call consultant rota.
- The ratio of consultants in the department was better than the England average of 23% of staff being at consultant grade with 25% of staff being at consultant level in this emergency department.
- Middle grade staffing (16% against the average of 13%) and registrar staffing (41% against the average of 39%) was better than the England average.
- Junior medical staffing was lower at 18% against the England average of 24%, however the number of junior medical staff was determined and allocated through the local medical deanery and was out of the trust's control.
- Locums were used within the department with between 17% and 30% of the medical rota being supported by locum doctors. The locum doctors in use were known to the service and frequently used. We were informed that two of the locum consultant grade doctors had taken permanent positions with the trust.
- We viewed the training records of the locum consultant which evidenced that all locum staff received a comprehensive induction to the department.
- The medical handovers we observed were short and did not provide a level of detail we expected from a medical handover within an emergency department; this was further supported by feedback from junior doctors in the department, two of whom told us they would like some more information through handover.
- Feedback provided to us prior to the inspection through medical trainee feedback also raised the points about medical handovers not being as detailed, robust or effective as they could be.

Major incident awareness and training

- 94% of staff within the department had received training in major incidents and awareness including the processes of decontamination in the event of a hazardous substance incident.
- Each shift had a trained staff member on duty who would coordinate the use of the decontamination suite and suits to be worn. The rotas we examined confirmed this by identifying the individual.
- We asked five staff and two members of the management team about major incidents specifically and all were able to clearly articulate what they would do in the event an incident was declared, where the policy was that they would need to refer to and what action cards they would need to implement in the event of an incident.

Are urgent and emergency services effective?

(for example, treatment is effective)

Outstanding



We have rated urgent and emergency services as outstanding for being effective because:

- The National Audit on Severe Trauma (Trauma Audit & Research Network, TARN) for 2014 showed that the trust performed better on trauma than any other trust in the East of England on survival rates, unexpected survival rates and data submissions.
- There was a clear protocol for staff to follow with regards to the management of stroke and sepsis.
- The fracture neck of femur pathway between the emergency department and the orthopaedic service was outstanding due to the reconfigured pathway in place which meant that consistent care was continually provided.
- We reviewed the pathway of two patients admitted with a stroke and observed outstanding practice in relation to the MDT working and process of moving the patient through the pathway quickly and effectively.
- The emergency department team undertake a range of more than 50 local audits per year on top of the national audit requirements. There are nursing and medical

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audit leads and evidence of learning from audits were demonstrated to us by staff and through staff, governance and audit meetings where they were discussed.

- There was clear evidence of continual learning of audits to improve the service with audit outcomes and improvements being tested and learnt from to improve care.
- The department also runs a series of improvement projects, chosen by staff, who support the completion of the projects to improve safety and patient care including nurse requested X-ray protocol, epistaxis protocol, fast track renal colic protocol, fast track hip dislocation protocol. These were well established and working well at the time of our inspection.
- The department was trialling new and innovative ways of managing pain and severe pain for patients within the department. All patients spoken with informed us that their pain needs were always being assessed.
- There were well established and clear processes in place for assessing patients in accordance with the Mental Capacity Act 2005 in the department.
- The Royal College of Emergency Medicine audit on the initial management of the fitting child showed that the trust met all five indicators required and performed in the upper quartile of England on two of the five areas assessed.
- The trust's unplanned re-attendance rate within seven days was consistently below the 5% standard between January 2013 and October 2015 with an average of 3%.
- The department operates a range of admission avoidance programmes including diabetes, deep vein thrombosis (DVT), ulcers clinic, wound clinics and pain clinics.

Evidence-based care and treatment

- There was a clear protocol for staff to follow with regards to the management of stroke and sepsis. The department had introduced the 'Sepsis Six' interventions to treat patients. Sepsis Six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. Bundles were also available for neutropenic sepsis.
- We examined the records of four patients with suspected sepsis and the pathways were followed at every step, and the records of the sepsis care was excellent.

- We reviewed the policies and pathways for the admission of stroke, fractures and chest pain and these were written in line with the national institute for health and care excellence (NICE) and CEM guidelines.
- The fracture neck of femur pathway between the emergency department and the orthopaedic service was outstanding. The department provided care to patients in accordance with CEM guidelines and their management plan for patients with a fractured neck of femur meant that patients could be treated in the ambulance bay, corridor or in the main department and their treatment would be of the same standard.
- When the department was very busy patients would often be cared for outside the main area but the pathway and access to pain relief, x-ray and the wards remained the same.
- The trust had a hyper acute stroke service and a clear pathway for when an acute stroke would arrive in the emergency department. The service linked with the acute stroke team to provide care in accordance with the pathway with a direct transfer to the ward via the CT scan. We reviewed the pathway of two patients admitted with a stroke and observed outstanding practice in relation to the MDT working and process of moving the patient through the pathway quickly and effectively.
- The emergency department team undertake a range of more than 50 local audits per year on top of the national audit requirements. There are nursing and medical audit leads and evidence of learning from audits were demonstrated to us by staff and through staff, governance and audit meetings where they were discussed.
- The range of local audits undertaken included anaphylaxis, missed diagnosis, discharge letters, decision to admit or decision to discharge, care record completion, record completion and communication.
- The department also runs a series of improvement projects, which are chosen by staff, who support the completion of the projects to improve safety and patient care. The projects for 2015 included, but were not exclusive to, a dedicated 24 hour per day reception service for ambulance patients to support prompt patient handover, hot debriefs in response to potential VHF case management, nurse requested X-ray protocol,

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epistaxis protocol, fast track renal colic protocol, fast track hip dislocation protocol and consultants becoming resuscitation trainers for the department to support mandatory training.

- At the time of the inspection we observed that the majority of these projects were well established and working well. The management team informed me that they were on schedule to complete their projects list for 2015.

Pain relief

- The trust performed 'about the same' as other trusts in the question in the 2014 CQC A&E Survey regarding the time patients had to wait to receive pain medication after requesting it (6.3 out of 10), and for patients' responses on whether they thought the hospital staff did everything they could to help control their pain (7.9 out of 10).
- College of Emergency Medicine (CEM) Pain in Children audit showed that the service performed in line with the England average with one indicator and better than average on three of the four indicators but lower than the expected range from CEM.
- The indicator that was not met was the providing analgesia on arrival, which we determined through the inspection was linked to not always having a staff member on triage who could administer pain relief, which has been detailed through medicines in the safe domain of this report.
- The College of Emergency Medicine Abdominal Pain audit 2014 showed that only 10% of patients were offered pain relief within the first 20 minutes of arrival, and 56% had a pain score recorded on arrival.
- The staff provided us with their action plan to improve their response to abdominal pain and their most recent audit results for September 2015. This showed that all points of their action plan had been achieved and 80% of patients were offered pain relief on arrival and 100% had a pain score recorded on arrival.
- The department had undertaken a review of pain relief and when to administer this within the department through learning from a complaint which was received in early 2015. The department successfully trialled the use of IV pain relief, such as IV paracetamol, administration to patients in the monitored corridor areas. This trial proved successful and has been factored in to the departments escalation plan.

- The department is trialling the use of IV morphine to patients in monitored corridors as well to support further interventions in pain relief.
- Where patient was identified as in significant pain, for example if they had sustained a major fracture, the RAT team would assess this and offer a pain relief block to the affected area to relieve discomfort. This was a method frequently used on patients with fractured legs, and was a successful pain intervention introduced to patient pathways in the department.
- We spoke with ten patients about their pain, two children and four relatives who all informed us that their pain needs were met and pain relief options were provided regularly.

Nutrition and hydration

- The trust performed 'about the same' other trusts in the question in the national 2014 CQC A&E Survey relating to access to suitable food or drinks when they were in the A&E department (6.6 out of 10).
- The service provided dedicated drinks rounds to patients and their friends or family with them throughout the day and the evening to meet their needs. This service was available 24 hours per day.
- Patients who were admitted to the hospital but were not able to access a bed within four hours were offered and provided with an inpatient meal whilst in the emergency department. We observed the catering team asking the patients for their food choices for their next meal, which was offered through the inpatient menu.
- We reviewed the records of two patients who were on food and fluid charts in the emergency department following their admission, these were completed at regular intervals and with a good level of detail on what was eaten and drank.
- We spoke with several relatives about their nutrition and hydration needs and all informed us that they had been regularly offered food and drink.

Patient outcomes

- Results from the 2014/15 Royal College of Emergency Medicine audit on the initial management of the fitting child showed that the trust met all five indicators required and performed in the upper quartile of England on two of the five areas assessed, which were

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all children actively fitting on arrival had their blood glucose checked and documented, and all children had eye witness history recorded which is in line with the standard of 100% for both areas.

- Of the 11 standards in the 2014/15 Royal College of Emergency Medicine audit on Mental Health in the emergency department the trust met all but four standards. The trust achieved the upper England quartile for risk assessments undertaken, provisional diagnoses recorded and assessment by a Mental Health practitioner, and the bottom quartile for documentation of mental state, documentation of follow up arrangements and assessment by a mental health practitioner from the organisation's specified acute psychiatric service.
- The June 2015 sepsis audit demonstrated that performed in the upper quartile of England on four of the five indicators, and met the other indicator of obtaining blood cultures. The service had reviewed the audit findings which showed a 66% compliance rate with this standard and implemented process changes. The re-audit undertaken in October 2015 demonstrated an improvement to 90%.
- We reviewed the current status of the mental health audit for 2015 and were provided with a comprehensive plan to improve the areas previously reported with concerns. The plans had actions which had all been implemented. The most recent audit results which had been submitted for the 2015 audit would place the trust as meeting all requirements or performing better than other trusts. This demonstrates that they have significantly improved where any concerns were identified.
- The trust's unplanned re-attendance rate within seven days was consistently below the 5% standard for January 2013 and October 2015 with an average of 3%, with the exception of March 2014 and March 2015, as well as also a large spike of 11% in November 2014.
- National Audit on Severe Trauma (Trauma Audit & Research Network, TARN) for 2015 showed that the trust performs better on trauma than any other trust in the East of England. The audit stated that 'survival rates continue to improve and are currently the best in the region at 2.9 additional survivors per 100 for January 2013 to December 2014'.
- The TARN data submissions are consistently above the average of 80% with submission of data rates at 85-90%, again making the trust the best in the region.

- The TARN report evidenced that the trust has three times as many unexpected survivors than unexpected deaths for the calendar year 2014, which puts them with the best outcomes of any trust in the region.
- The Assessing for Cognitive Impairment in Older People audit from the Royal College of Emergency Medicines 2014/15 showed that the service achieved five of the six standards. Of these standards the trust performed in the upper quartile of the country on five of the six standards and was slightly below the standard of communicating with the GP. This was the first year this audit had been used nationally.
- The trust provided us with an action plan on the recommended points for improvement and provided us with evidence during the inspection, which demonstrated that they had improved on all of the key standards to improve the assessment for older people.

Competent staff

- All medical staff within the department have been revalidated by the GMC. Nurses within the department have a process in place through their one to one and appraisal processes where they are preparing nursing staff for revalidation during 2015.
- Within the department 58% of nursing staff and 78% of medical staff have had an appraisal within the last 12 months. Those who have not yet been appraised are either on maternity leave, sick leave or secondment and there is a comprehensive appraisal plan for the year to ensure all staff are appraised, and when taking these individuals out the numbers it equates to 88% of nurses and 96% of doctors being appraised.
- Nursing and medical staff have one to one meetings and clinical support sessions to improve skills and competencies, and identify training needs for staff. We saw evidence of meetings that were held with staff every six to eight weeks to discuss their clinical skills and their working time in the department as part of their development in the service.
- Staff who worked in the department had access to further development opportunities including additional qualifications, such as becoming a nurse prescriber or advanced nurse practitioner. For healthcare assistants they are educated to senior level and offered the opportunity to train and qualify as registered nurses if they wanted to progress their careers.

Multidisciplinary working

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- The service has a good working relationship with the ambulance trust who convey patients to the hospital. The HALO and the paramedics we spoke with were all positive about the working relationship with the hospital and were complimentary about the changes since they introduced a dedicated reception area for the ambulance arrivals.
- The service has an outstanding multi-disciplinary working arrangement set up with the community service who provide support to the urgent care centre. Throughout the inspection we observed excellent working between the two teams.
- The department has established pathways in place, with good working relationships with the stroke, cardiology, oncology, acute medical, surgery and oncology teams.
- The department has created dedicated pathways with lead nurse roles on each shift for mental health, alcohol liaison and substance misuse. These staff liaise with the local support services and ensure the needs of the patients are met.
- The department operates a range of admission avoidance programmes including diabetes, deep vein thrombosis (DVT), ulcers clinic, wound clinics and pain clinics. The audits the service had undertaken on these clinics showed that there had been a reduction in admission of all patient groups. The minimum avoidance was noted at 15% for pain and 35% for diabetes, which was excellent.

Seven-day services

- The emergency department for adults and children was open seven days per week and 24 hours per day.
- There is a GP access service available on site through the community run urgent care centre, which was also open seven days per week but for 12 hours per day.
- Radiology services currently operate seven days per week for the emergency department.
- Pharmacist and therapy support was also available to the emergency department seven days per week.

Access to information

- The department used one main system, called Symphony, record the patient pathway through the emergency department, and all staff had access to this.
- There were computer points throughout which displayed the system as well as the ambulance arrivals and handover times for information.

- Staff could access patient systems including the administration, radiology and pharmacy systems through a range of computer points in the department and by using the NHS information access cards.
- In the event a patient's medical records were required they could be accessed by the department at any time upon request.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Within the emergency department 100% of nursing and support staff and 86% of medical staff had received training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Staff carried pocket notes with them which provided readily accessible information on the Mental Capacity Act 2005 as a helpful guide when they required it.
- We asked three nurses and one doctor specifically about the Mental Capacity Act 2005 and all were able to clearly articulate what was required of them as healthcare professionals.
- We examined the mental capacity assessment of two patients in the department who required them and these were completed appropriately by the medical and nursing team, and resulted in appropriate social care referrals being made.

Are urgent and emergency services caring?

Outstanding



We have rated urgent and emergency services as outstanding for being caring because:

- We consistently saw all types and grades of staff from nursing, support, portering and domestic staff going above and beyond the call of duty to provide outstanding care to patients, relatives, families and other staff.
- We spoke with 23 patients and six relatives of patients or members of the public, all of whom were overwhelmingly positive about the care and service they received. All said that they would happily be treated at the service and have their family treated at the service. We received no negative feedback from anyone we spoke with as part of this inspection.

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- We spoke with paramedics who were all positive about the service and all expressed how they would choose to come to this emergency department over others in the area and would happily bring their friends and family to the emergency department for treatment.
- Between January and October 2015 the trust performed better than the England average on the friends and family test for eight out of the ten months, with June to September being much higher than the England average with scores between 93% and 96% against the England average of 88%.

Compassionate care

- This trust performed about the same as other trusts for all questions relating to compassionate care in the 2014 CQC A&E Survey. Scores ranged from 3.5 out of 10 for communication of waiting times to patients, to 9.2 out of 10 for the question regarding whether staff relayed conflicting information to patients.
- Friends and Family Test scores for the emergency department in October 2015 were 93%. Low response rates are common for A&E friends and family tests, so scores should be interpreted with caution. In October 2015, the trust's response rate for this survey was 8%.
- Between January and October 2015 the trust performed better than the England average on the friends and family test for eight out of the ten months, with June to September being much higher than the England average with scores between 93% and 96% against the England average of 88%.
- We observed numerous examples of outstanding care from a team committed to providing good care to patients throughout the inspection. We observed one doctor sitting and talking with the family to give them some bad news and they broke the news in a very private and dignified way, and also spent time with the family to answer the questions they had. We observed the doctor then return at two further intervals to speak with the family offer them comfort and to check on their welfare.
- We were informed of a case where a family had been involved in a traumatic event. Two staff members recounted to us how a healthcare assistant looked after the child who was worried where their parent was. The staff reallocated their workload to free the healthcare assistant to provide dedicated care to the child who was distressed, and the healthcare assistant sat on the bed with child reading books to calm and reassure them. We spoke to the healthcare assistant who was referenced in this story who informed us that they saw what they did as part of their job and that they felt privileged to be able to do it.
- In another case we observed the family of an unwell patient be comforted by a staff nurse and care assistant whilst their relative was being taken up to theatre for surgery. We observed the family say to the staff that they wanted to the staff to be with their relative, the staff responded by saying, "we have a team with them, we are here for you", which was supportive and reassuring to the family.
- We observed staff implement their teams for a child death that occurred within the department, and provide dignified care and support for the child and the family within the department, as well as speak and reassure the ambulance and police staff who arrived to control the scene. The staff were observed throughout an eight hour period to provide a dedicated team to continually care, speak and support the affected family. The managers took staff aside in turns to ensure that staff welfare was being maintained. The care provided to all during this observation was outstanding.
- We spoke with 23 patients and six relatives of patients about their care in the emergency department. All were overwhelmingly positive about their experience of using the emergency department with comments being provided to us including, "staff are just amazing", "they can't do enough for you", and "I wouldn't go anywhere else".
- We spoke with 14 visiting members of the ambulance service about their experience of their service and whether they would be happy to be treated at the service, or have any of their family treated at the service. They unanimously responded that this was the hospital in Norfolk they would choose to go to and they would have no concerns with their family being treated there as the care was outstanding in their view.

Understanding and involvement of patients and those close to them

- Patients were routinely updated regarding their plans of care by their named nurse whilst in the department. We spoke with 23 patients during the inspection and all were aware of their plans of care, and informed us that they felt that they had all the information that they needed.

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- We spoke with six patients who were admitted as inpatients, but remained in the department due to bed capacity issues, who were all informed of the reason for their delays for admission but informed us that they had been kept updated by staff on what was happening and that they had no questions regarding their care.
- We spoke with six relatives of patients who used the service who were all positive about how much they were included in the care and planning of care for their relatives, and none of the relatives we spoke with had any concerns regarding care.

Emotional support

- Clinical nurse specialists were available to provide specialist support to patients in the department, and staff who worked in the department were able to tell us the range of specialists they could access for both adults and children including orthopaedic nurse, learning disability nurse, safeguarding children's nurse, acute stroke nurse, and Parkinson's specialist nurse.
- The department had access to dedicated counselling services for staff affected by the cases they deal within in the department, as well as a dedicated counselling and support service for a range of conditions for patients and relatives including mental health, alcohol liaison, drugs support, cancer support, carers support.
- Patients and staff had access to the chaplaincy service who offered support to patients and staff seven days per week, and they walked through the department at least once per day.

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Good



We have rated urgent and emergency services as good for being responsive because:

- Staff had access to a translation service through the telephone known as language line. This telephone service was available to the department 24 hours per day seven days per week.

- Leaflets on a variety of conditions including back pain and flu as well as choosing the right pathways of care and when to choose emergency care were available to patients.
- Information was available through posters displayed throughout the department to inform patients on support processes to help living with long term or chronic conditions such as diabetes and pain and how to obtain information to avoid admissions.
- The service had a dedicated area for relatives with three individual relative rooms for speaking with patients and their families and breaking bad news. These rooms had signs on the door to alert staff when they were in use and when not to be disturbed.
- During our inspection we observed that some patients were in the emergency department for between 12 to 18 hours at times which was not responsive to their needs, however the team within the emergency department allocated staff to provide dedicated inpatient care rounds, food and drink rounds and personal care to ensure their inpatient needs were met.
- We found that the data was accurate with four hour performance being low with an average performance of 89% to 92% over the last three months, however the emergency department were being let down on achieving this due to the bed capacity issues within the hospital. The delays and breaches came due to a lack of bed availability.
- The department had a robust process for learning from complaints and implementing and embedding changes following receipt of complaints to improve patient care.

However there were some areas that could be improved because:

- The trust support for the emergency department required improvement by owing the four hour target as a trustwide concern, by improving capacity and flow through the hospital would improve the four hour performance.

Service planning and delivery to meet the needs of local people

- The service undertook reviews to establish how many patients may require the use of the service on a daily basis, and this process enabled them to balance their staffing and resource effectively.

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- The service fully recognised that the size of the department is no longer able to cope with the demand placed on the service. The department was originally built to see 70,000 people per year but now sees upwards of 110,000 people per year.
- The department were engaged in a planning and rebuilding project which involved all stakeholders to look at delivering a more responsive service, however due to a change in executive team the plans that had been agreed had been placed on hold at the time of our inspection until a further review could be undertaken to ensure it was cost effective.
- Information was available through posters displayed throughout the department to inform patients on support processes to help living with long term or chronic conditions such as diabetes and pain and how to obtain information to avoid admissions.
- There was a dedicated gynaecology cubicle and room for women to wait whilst they received treatment, so that they could be cared for in a private area to maintain dignity whilst going through a traumatic event.
- The service has a dedicated area for relatives with three individual relative rooms for speaking with patients and their families and breaking bad news. These rooms had signs on the door to alert staff when they were in use and when not to be disturbed. We observed these rooms being used appropriately during the inspection, and relatives were allowed to remain in them for as long as they required.
- During our inspection we observed that patients were admitted to the hospital and were 'lodging' in the emergency department on inpatient beds waiting to be moved to a ward. We observed that some patients were in the emergency department for more than 12 hours at times which was not responsive. Over two days we observed 14 patients lodging in the department awaiting an inpatient bed who had been there for more than 12 hours, though this data had not been validated at the time of the inspection only observed.
- The department was on black alert and experiencing exceptionally high demand at the time of the inspection. The trust did not declare any 12 hour trolley breaches during this period as they had officially classed patients who had waited more than 12 hours as lodging patients in accordance with NHS data requirements.
- However the team within the emergency department allocated staff to provide dedicated inpatient care with care rounds, food and drink rounds and personal care to patients who had been in the department for more than four hours to ensure their inpatient needs were met.

Meeting people's individual needs

- The children's service were working with children and young people's mental health services (CAMHS) to ensure that services for children and young people could be accessed in a more timely way.
- Mental health liaison services were available in the trust Monday to Sunday and could be accessed whenever the department required their support. There were often delays associated with the mental health team availability. As a result of this staff had been trained and received additional awareness support to meet the needs of people with a mental health condition which has improved the care and experience of people with mental health concerns who attended the service.
- Staff had access to a translation service through the telephone known as language line. This telephone service was available to the department 24 hours per day seven days per week.
- There was a named nurse for learning disabilities and staff had received training in understanding learning disabilities and complex needs. The nurse was available Monday to Friday, however information is available to staff on the intranet to support them with a patient who has complex needs if required.
- The trust had a named nurse for dementia and the service had access to this person Monday to Friday where needed for advice and guidance.
- Leaflets on a variety of conditions including back pain and flu as well as choosing the right pathways of care and when to choose emergency care were available to patients throughout the department. The leaflets available were in English only although other languages were available where the first language was not English.
- The proportion of patients leaving before being seen increased from 1.2% in April 2014 to 3.5% in July 2014. Since then, the proportion has fallen in line with the England average.

Access and flow

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- The total time in A&E has been longer than the England average since May 2014. The most recent figures (May 2015) show that on average patients are waiting 148 minutes, compared to an England average of 137 minutes.
- The trust has only met the 95% four hour waiting time standard three times since August 2014. Between January and June 2015 performance improved from 81% to 96%. Between June and October 2015 the performance against the four hour standard ranged from 89% to 92%.
- A&E waiting times more than four hours were highlighted as a risk in the CQC May 2015 Intelligent Monitoring report.
- Fewer patients are waiting four to 12 hours from the decision to admit, compared to the England average (2.6% in June 2015 compared to 4.7%). This proportion fluctuated over time, in line with the England performance.
- Between 31 March 2014 and 28 June 2015 there were 1,790 people waiting four to 12 hours and one person waiting over 12 hours from decision to admit to admission.
- We looked in detail at the concerns regarding the four hour performance time and also the time from a decision to admit being made and the admission times. We specifically monitored 100 patient pathways over the three days of our inspection as our evidence of this.
- We found that the data was accurate with four hour performance being low with an average performance of 89% to 92% between June and October 2015, however the emergency department were being let down on achieving this due to the bed capacity issues within the hospital.
- The emergency department was successfully achieving time to initial assessment and treatment with the majority of patients being seen within an appropriate time frame and a decision to admit being made within three hours of arrival. The delays and breaches came due to a lack of bed availability.
- Of the 100 pathways we looked at through the symphony system we observed that 99% of patients had received initial assessment within 15 minutes, 97% had received treatment within 60 minutes and 88% had a decision to admit or discharge be made within three hours and 100% had a decision to admit or discharge within three and a half hours. This meant that department was being responsive to the needs of people by providing the essential standards of care for patients.
- The department had a surge capacity protocol which was well used within the department. The emergency department can declare a status which is separate to the trust's overall status dependent on the number of people who attend the department.
- We observed the department activate their capacity protocols at various stages throughout the inspection. This included the use of their escalation areas in the corridor, where we observed how the staff on shift would immediately go into the capacity mode to provide care to patients in the corridor. We also observed how an additional triage and assessment area would be created to support demand where required and the RAT team respond and go into the ambulance bay.
- There was a fluidity in team working which enabled them to transition between a normal working arrangement and working under surge capacity requirements. The care we observed throughout this process was safe and responsive.
- The surge protocol within the emergency department enabled the team to look at access and flow and ensure that patient's pathways through the system progressed as quickly as possible. For example we observed a patient with a fractured neck of femur go from the ambulance service to the x-ray department, back to the corridor and then to the ward within one hour once their fracture was confirmed. The service's approach to surge and capacity management was innovative and worked very well.

Learning from complaints and concerns

- The trust received 993 complaints between 1 September 2014 and 01 September 2015. The emergency department received 19 complaints during this time. The most common themes of complaints were delays, waiting times, and communication.
- Complaints and concerns were discussed at each team meeting, governance meeting, staff meeting and directorate meetings. We viewed minutes of meetings at all levels which supported that learning from complaints was discussed.

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- The matron took us through their matrix for monitoring the learning and improvements from complaints and had a log which monitored learning from complaints as any changes were implemented in the department to ensure that those changes were embedded.
- The matron was able to provide explicit examples of practice changes as a result of patient complaints being raised. The department had undertaken a review of pain relief and when to administer this within the department through learning from a complaint which was received in early 2015. The department successfully trialled the use of IV pain relief, such as IV paracetamol, administration to patients in the monitored corridor areas, and have now fully embedded this practice as an improvement in patient care.

Are urgent and emergency services well-led?

Good



We have rated urgent and emergency services as good for being well led because:

- The culture of the nursing workforce was outstanding with a well established nursing team. The nursing leadership within the service, particularly at matron level, was outstanding.
- The recently appointed clinical lead had a vision for the service, and knew what was required to improve the service. The trust had also provided external support to help strengthen the medical body in the service.
- There was a strong culture of governance and risk management within the service. The governance structures including meetings, learning, audits, and risk registers were well established and well known within the team.
- The service had a defined vision and strategy for the future, and this included the staff who contributed to the vision of the service and where they wanted to take the service to over the next three years. The staff were all aware of the trusts vision and values.

However there were some areas that could be improved because:

- The attitude of medical staff and the culture of the consultant body in relation to how they work with the

nursing staff and respond to the leadership team needed improvement. We observed some disrespectful interactions between nursing and medical staff at times. The trust did take action to improve this throughout the inspection and there was a notable improvement by the time we undertook the unannounced inspection.

- The consultant in command role on shift was new and was not working efficiently to provide clear and constructive leadership to the medical workforce at all times and required review.
- The attitude of the operational and management teams towards the emergency department, at times, affected the morale of staff with pressure to move patients through the department to meet the four hour target meant that staff felt blamed for not performing when it was evident they were working to their capacity with the bed spaces available.

Vision and strategy for this service

- The leadership team for the emergency department had a clear vision for the service and had defined plans for the future development and progression of the adult and children's services. Staff told us that they had these plans approved and were ready for the renovation and building to commence, however the trust executive team had halted the plans for the service, and this meant that the expansion and strategy had changed.
- Staff were aware of the core values of the organisation and could articulate these to us. They were aware of the vision of the trust and the changes that were likely to take place following a change in the executive team.

Governance, risk management and quality measurement

- The emergency department had robust governance arrangements in place which included risk management with incident reporting and complaints management, audits both local and national, risk assessments of the department and the completion of the local risk register.
- We reviewed the risk register for September 2015 provided to us by the trust and discussed this with the leads of the service. They also provided us with the October 2015 register on site. The risk register had 16 items listed on it including the environment, staff stress levels, handover delays and the concerns regarding the environment for children in the emergency department not being fit for purpose.

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- We discussed the risks which we had identified during the inspection; all matched what the service had identified as their own risks and were in agreement with the risks we had identified, particularly with regards to the children's emergency department which was not safe.
- The trust had put mitigating factors onto the five top risks within the emergency department which took their risk rating from red to amber, which meant that they were not required to be escalated to the trust board assurance framework. The item that remained on the board assurance framework was the need to be more consistent in achieving four hours.
- The leadership team from band 7 level and registrar level to divisional management and clinical director level were all consistent with what they believed the key risks were for the service, what challenges they faced and what they needed to do as leaders to make improvements.

Leadership of service

- The nursing leadership at matron within the department was outstanding, with the matron for the service being a well respected leader and an integral part of the team.
- The nursing leadership team at band 6 and 7 were also outstanding and had a clear leadership style which encouraged staff working through each shift.
- The medical leadership had recently changed with a clinical lead being recently appointed. The clinical lead had a clear vision to improve medical leadership and teaching within the service, and it was evident that they had the support of the divisional managers and executive management team to make the necessary changes.
- The trust has brought in an external consultant to support the further development of leadership and engagement within the emergency department.
- The divisional leadership team for the division had a clear understanding of the strengths, weakness, successes, and challenges faced by the emergency department. There was an embedded management working arrangement with the leadership team and a will to improve the service, to make it outstanding.
- The medical leadership within the emergency department was managed on each shift by a 'consultant in command' this role is the senior consultant on duty who coordinates the medical staff and works with the

nursing team. We observed during the inspection that this role was not functioning well and required review to make the role of the consultant in charge more effective and efficient as a leader.

- This was further evidenced by observing on two occasions junior doctors asking for instructions on what the consultant wanted them to do, and not being given a response that filled them with confidence in their leader. For example we observed one consultant respond that they were going on a break when they were asked by a junior doctor what they wanted them to do.

Culture within the service

- The nursing culture was one that worked to provide the best care possible to the patients and their families, and there was notable comradery amongst the nursing and support staff to deliver good care to patients.
- The medical staff in the department at junior level worked well together and with the nursing staff, however we observed there to be some inappropriate behaviours from the consultant doctors to the nurses at times. We observed on multiple occasions three consultants speak to nurses in a way which was not respectful.
- For example we observed one doctor asking the nurses to go and get them their coffee throughout the day, we observed one consultant in command leave their role to the nurse in charge for an extended period of time and then ignore their requests to come back and support them, and another consultant who informed us that "the nurses run this department we are just here for show and to make a decision".
- We asked the nursing staff about this attitude and we were informed that it had been this way for years, that they were used to hearing it and just worked around it to keep the service moving forward. They informed us that they had reported this to the previous executive leadership team but no action was taken to resolve it.
- We raised our concerns about the culture and attitude of the consultant team in the department to the executive team for their immediate action and attention. At the end of our inspection we were informed that action had been taken in respect of the three consultants concerned and further work to resolve this issue was planned.
- During the unannounced inspection we observed that there had been a significant improvement and a shift in

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the culture within the department with staff reporting to us that it had improved in the two weeks since the announced inspection. The staff also informed us that they were much happier and feeling very positive about the future.

- We observed during the inspection a culture of blame from the trust towards the emergency department for not achieving the four hour target or for avoiding breaches of patients being in the department for more than eight or 12 hours. We heard a phone call received by a nurse in charge from a manager within the site management team asking about what the team were doing to avoid further breaches. The nurse explained that they are doing what they can but that they had 13 patients to go to wards, currently on beds. The manager on the phone was heard to say that they needed to try harder.
- This was not an appropriate message to give when the department was striving to maintain flow whilst caring for a large number of inpatients due to a lack of capacity in the hospital, and the staff informed us that messages like this through the trust were common and negatively impacted on staff morale.

Public engagement

- The department sought feedback from the patients to engage them in the service through feedback forms, comment cards, the friends and family test and displayed posters throughout the department asking for their feedback to improve the service.

Staff engagement

- The emergency department regularly held briefing and debriefing sessions to engage staff about what was happening with the department and to provide key messages. This meeting was also used for the staff to speak to the managers and be open about any concerns that they may have had regarding the services for the managers to respond and resolve the issues raised.

- The staff are asked to take part in feedback sessions, pulse surveys and the annual staff survey to provide feedback.
- All staff we spoke with believed the management team were approachable and were engaged with the staff in running the service.

Innovation, improvement and sustainability

- The department is running a wide range of admission avoidance services through the emergency department to support patients. The department is continually striving to increase the number of support services to patients to help avoid admissions.
- The department is trialling the use of IV morphine to patients in monitored corridors as well to support further interventions in pain relief.
- The department runs a series of improvement projects, which are chosen by staff, who support the completion of the projects to improve safety and patient care. The projects for 2015 included, nurse requested X-ray protocol, epistaxis protocol, fast track renal colic protocol, fast track hip dislocation protocol and consultants becoming resuscitation trainers for the department to support mandatory training.
- The entire team from the emergency department were involve in the design plans for the renovation and expansion of the emergency department to make it better for patients. The plans were patient focused but also strategic to make the service work for the team in the long term.
- The clinical leaders were working to improve the recruitment of clinical staff through the use of the DREAM programme supported by the College of Emergency Medicine. This would allow for medical staff to rotate through hospital to increase medical staff cover and gain staff experience and skills prior to being made consultants within the service.

Medical care (including older people's care)

Safe	Requires improvement	
Effective	Good	
Caring	Good	
Responsive	Requires improvement	
Well-led	Requires improvement	
Overall	Requires improvement	

Information about the service

The trust admitted 80,023 medical patients between January 2014 and December 2014 making it one of the highest number of medical admissions in England. There are 18 medical wards within the trust which account for 656 beds. A wide range of clinical specialties are available including acute medicine, renal, neurology, rheumatology, cardiology and older people's medicine amongst others.

We visited 19 medical areas including the Acute Medical Unit for Men (M) and Women (L) and several other clinical areas including endoscopy, angiography/ catheter labs and the coronary care unit. We spoke with 42 patients and relatives, 48 members of staff including nurses, doctors, therapists, pharmacists, health care assistants and non-clinical staff. We reviewed records and observed care.

Summary of findings

We rated medical services as requiring improvement overall. Nurse staffing did not reflect the acuity of patients on all wards and we raised this concern during our inspection. On several wards there were a number of unfilled shifts for registered nurses. National guidance for staffing in relation to hyper acute stroke and non-invasive ventilation was not followed. There were a large number of vacancies for acute medical consultants in the acute medical unit with the clinical director being an interim position.

Infection control processes did not always protect people from exposure to infection. The environment in Mattishall ward remained sub optimal for patient care as there was no piped oxygen and the ward remained open at one end to the research area. However, this had improved since our last inspection. Staff were aware of their safeguarding responsibilities but training levels for safeguarding were below trust target as was other mandatory training. We were concerned that patients admitted to the AMU (M) and (L) were not all reviewed promptly, particularly GP referrals. We were also concerned that patients not meeting the referral criteria for Mattishall ward were routinely admitted to that ward.

Medical services were effective as care given was in line with national guidance and best practice. Staff adhered to local policy and procedures and the trust took part in numerous national and local audits. Pain relief was given in a timely way and patients were assessed for the

Medical care (including older people's care)

effectiveness of the pain relief given and patients received adequate nutrition and fluids and were supported where needed with other forms of nutrition. Patient outcomes were positive, the endoscopy unit was accredited and risk of readmission was better than the England average.

Friends and family test (FFT) scores were generally very positive for medical wards with the exception of the AMUL. We observed many examples of staff delivering compassionate care to patients and their relatives and carers. Patients told us they were actively involved in planning their treatment and were given options where possible.

Responsiveness required improvement because the ambulatory care service on the AMU did not have ring-fenced beds and was regularly used for inpatient beds. This meant ambulatory care was either restricted or suspended on a regular occasion with patients having to attend the AMU separately or the emergency department. Patients regularly had to wait in a public area whilst awaiting a bed on the AMU. This was either on chairs or ambulance trolleys and could be up to 2.5 hours. 121 patients were in hospital for more than 60 days between May and October 2015 and we were concerned there was a mixed sex breach on the AMU (M) ward. There was not enough specialist chairs on Dunston ward for patients to be able to sit out of bed. There was an excellent primary percutaneous coronary intervention (PPCI) service for patients with cardiac symptoms.

Staff were aware of the trust's vision and strategy but were unsure of that for the divisions or the clinical strategy. Senior staff were concerned there was not a strategy for managing over the winter. There was no clear strategy for the management of the AMU or ambulatory care. We had identified concerns on Mattishall ward in March 2015 as had Health Education East of England in their report in July 2015. Despite improvements it remained a suboptimal area for patient care. A large number of patients who were not meeting its admission criteria were placed there anyway. Root cause analysis reviews were poorly completed. Whilst mortality and morbidity was clearly discussed as specialism level, it was unclear how relevant learning could be shared with other specialisms. There was only

interim clinical leadership in a very busy and key department which had already seen a number of changes in the preceding 12 months. We also found enthusiastic staff and managers, passionate about improving patient care and services.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement



We rated medical services as requiring improvement because:

- Nurse staffing did not reflect the acuity of patients on all wards and we raised this concern during our inspection. On several wards there were a number of unfilled shifts for registered nurses. National guidance for staffing in relation to hyper acute stroke and non-invasive ventilation was not followed. Rotas showed there to be limited flexibility in relation to patient acuity.
- The environment in Mattishall ward remained sub optimal for patient care as there was no piped oxygen. The ward remained open at one end to the research area but security had improved since our last inspection.
- Staff were aware of their safeguarding responsibilities but training levels for safeguarding training were below trust target as was other mandatory training.
- We were concerned that patients admitted to the AMU (M) and (L) were not all reviewed promptly, particularly GP referrals. We were also concerned that patients not meeting the referral criteria for Mattishall ward were routinely admitted to that ward.
- There were large number of vacancies for acute medical consultants in the AMU with the clinical director being an interim position.

However, we also found:

- Incidents were reported and feedback usually given to staff, although root cause analysis was sometimes poor.
- Safety thermometer data was visible and showed positive information.
- Medicines were stored and administered correctly, although not all fridges were checked daily as per trust policy.
- Records were of good quality; risk assessments completed and updated in response to changing needs.

Incidents

- The trust reported 68 serious incidents between August 2014 and July 2015, including 35 pressure ulcers and 27 slips, trips and falls. None of the serious incidents were classified as never events.

- Incidents were reported electronically via the trust's electronic incident reporting system Staff we spoke with, including four bank and agency staff, were able to report incidents.
- Staff said that they received feedback on incidents that happened in their areas, usually by way of a meeting or newsletter. Meeting minutes we reviewed showed that feedback regarding incidents was given with the exception of minutes from June 2015 for Older People's Medicine that stated staff did not always get feedback on incident forms.
- We reviewed two root cause analyses (RCA) completed in response to two incidents within the medical directorate. They were poorly completed and the root cause identified was not in fact a root cause of the incidents. We were concerned that learning from incidents could not always be identified if the correct cause of the incident was not clear.
- In the catheter lab the top five incidents were identified and there was an action plan in place for each one.
- Meeting minutes showed that mortality and morbidity was discussed at governance meetings for each specialty such as cardiology and neurology. Minutes were comprehensive and included appropriate case review. It was not clear how learning would be shared between specialities in the event of a wider learning need.

Duty of Candour

- Staff had a variable understanding about Duty of Candour. All understood the need to be open and honest with patients when things go wrong but some staff were unaware of the need to make an apology and meet with the family. They were also unclear about how to identify when Duty of Candour should be triggered.

Safety thermometer

- Patient Safety Thermometer data showed variable rates of pressure ulcers between July 2014 and July 2015, with a total of 86 pressure ulcers reported during this period. The rate of falls increased slightly over the same period, with a total number of 38 reported. There were 56 catheter urinary tract infections in the same period, with an overall trend of the rates falling.
- Safety thermometer data was clearly displayed on each ward. Data showed no incidents of MRSA bacteraemia on all wards and lower levels of *C. difficile*.

Medical care (including older people's care)

- Data on Kilverstone ward showed a pressure ulcer in September 2015 with the last one being May 2015. There were a total of six falls on Kilverstone ward in August and September 2015. Heydon ward reported nine falls in September and an action plan was in place for this. However the data showed low levels of pressure sores. Data for AMUM showed no cases of *C. difficile* and two falls for September 2015.

Cleanliness, infection control and hygiene

- There had been no methicillin resistant staphylococcus aureus (MRSA) bacteraemia in medicine for more than 1 year. There were seven methicillin resistant staphylococcus aureus (MSSA) bacteraemia between April 2014 and March 2015. Screening compliance for MRSA was consistently above 98% for elective patients and above 90% for emergency patients. Latest data showed one case of MSSA bacteraemia in July 2015
- All trusts are set a ceiling for the numbers of infections of *Clostridium difficile*. The trust was below ceiling for 2014/15 *C. Diff* infections (41 against a ceiling of 50). The trust ceiling for 2015/ 16 is 49 cases. There had been 19 as of July 2015.
- In this trust, 58% of staff within the medicine core service had completed the mandatory training for infection control, compared to the trust's November target of 85%.
- Most staff followed infection control policy in clinical areas. Staff were bare below the elbows and used appropriate hand hygiene.
- There was enough personal protective equipment in clinical areas and staff were observed using gloves and aprons correctly.
- Sluice areas were visibly clean and tidy. Commodes had 'I am clean' stickers affixed to show they were ready for use. The macerators had a daily cleaning schedule that was completed where checked.
- On one ward staff were cohorting patients in a bay as there were concerns that one patient may have norovirus. The other three patients were not thought to have norovirus but staff said that there were insufficient side rooms to isolate the patient effectively. We were concerned that the other three patients in the bay were put at increased risk of contracting norovirus because of this arrangement. We observed one of the patients frequently leaving the bay. Staff said that one patient was not as cooperative with infection prevention measures. One senior member of staff said that a

shortage of side rooms in the acute medical units meant this was the only practical way to isolate patients. We were further concerned that staff were not identifying appropriate patients to cohort in isolation bays. We observed two staff leave this bay without washing their hands.

- Hand hygiene audits on wards showed above 90% compliance for most wards with a number being at 100%.
- One bathroom was used as a storage room. Within the room was a sink that was dusty and had not been used. A member of staff stated that they did not believe the sink was used frequently.
- The recently refurbished memory room on Holt ward had antibacterial, washable wallpaper to allow for effective cleaning of the room.

Environment and equipment

- Most equipment we checked was serviced in line with manufacturer's recommendations. We found one combined ophthalmoscope/ auroscope in the bathroom/ storeroom on Guist ward that was last due to be serviced in June 2015. Staff were unable to confirm if the sticker attached was correct or if the unit had been serviced.
- Equipment that required portable appliance testing (PAT) had been appropriately tested.
- All resuscitation equipment had been checked in line with trust policy. All equipment and medicines were found to be in date.
- When we inspected in March 2015 we were concerned that Mattishall Ward was not a suitable or safe environment for patient care. A Health Education East of England report in July 2015 had similar concerns regarding patient care.
- During this inspection we saw that all patient rooms now had windows which they did not before. The ward still relied on bottled oxygen and portable suction as the ward had initially been built as part of the medical school. New toilets had been installed as well as a new medicines room. A sluice dedicated to Mattishall ward only was now in place. We remained concerned that one end of the ward remained open to the research unit (effectively the other part of the ward) partitioned by a screen and not a partition wall.. This did not provide adequate privacy or security.

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- The store room in the endoscopy unit was found to be left open with the key in the door. There was out of date equipment in the room that we were told was for staff training.

Medicines

- In this trust, 79% of medical staff and 81% of nursing staff within the medicine core service had completed the training on medicines management. This was above the trust's target of 75%.
- On Gunthorpe and Dunston wards there were three gaps in each record for daily fridge temperatures checking in November 2015 and two gaps on Elsing ward for the same period. Heydon ward had nine gaps in September 2015 and eight gaps in October 2015 fridge temperature records.
- On Guist ward one patient said that they had not felt empowered to manage their medication when initially admitted to ward. The ward manager was aware of this problem and had responded and enabled the patient to manage their medications within the trusts policy and procedures.
- The pharmacy team provided a well-established and comprehensive clinical service to ensure people were protected from avoidable harm. The pharmacy team visited all wards each week day, and there was a limited service at weekends. Pharmacy staff were particularly well integrated into the cardiology wards and the admissions areas. There were pharmacy teams based on the wards to respond rapidly to requests for stock, take home medicines and information. There is a plan to extend the admissions service to seven days a week following a recent successful pilot.
- Pharmacy staff reviewed and confirmed the prescriptions for people on first admission to hospital. Medicines interventions by a pharmacist were recorded on the prescription charts or electronic prescription system to help guide staff in the safe administration of medicines.
- We looked at the prescription and medicine administration records for 25 patients on four wards. There were audits to show that missed doses had been a problem in some wards. However, measures had been taken to improve medicine administration. Prescription charts were generally well completed to show that people received their medicines as prescribed. Patients said that they were given pain relief when needed.

People who were in hospital for a short time were supported to look after their own medicines. We heard a nurse explaining what each medicine was for and giving the person advice on the best time to take them.

- There was a pharmacy top-up service for ward stock and other medicines were supplied by the pharmacy team on an individual basis. Nursing staff stated that they received an excellent service from the pharmacy department during the day, and that there were arrangements in place to obtain urgent medicines out of hours.
- On one ward, which looks after people living with dementia, nursing staff did not have a good understanding of how to assess people's capacity to consent to medicines being prescribed and administered.
- Medicines were kept securely and locked with access to medicines room by number locks. A sample of medicines we checked all tallied correctly. All medicines and fluids were in date.
- E- prescribing had commenced at the trust when we returned for our unannounced inspection and staff were getting used to the new system.

Records

- We reviewed 56 records as part of this inspection. Records were kept in two places; at the end of a patient's bed and in a notes trolley.
- Notes were accessible for staff but were unsecured and we observed on two occasions notes being left out and unattended.
- Records were mostly well completed with risk assessments appropriately completed on admission and reviewed frequently during a patient's admission. These risk assessments included pressure damage, malnutrition and moving and handling amongst others. Trust audit data showed that more than 96% of venous thromboembolism assessments were completed correctly.
- There were a small number of minor errors or omissions in the records such as pressure risk scores miscalculated in three records and six fluid charts that were not correct when reviewed with the medicines chart.

Safeguarding

- The trust had a target of 75% for completion of training on safeguarding of children. Within the medicine and clinical support division, all staff groups met this target

Medical care (including older people's care)

for the Safeguarding Children (Level 1) module, except for allied health professionals (68%) and medical and dental staff (33%). For the Level 2 module, the staff groups failing to meet the target were: additional clinical services staff (71%), additional professional, scientific and technical staff (70%), healthcare scientists (67%) and medical and dental staff (64%).

- For the Level 3 module, all additional clinical services staff completed the training, except for allied health professionals, who achieved 70% completion against the target of 75%.
- Staff were aware of their safeguarding responsibilities and were clear how to make safeguarding referrals. Information in clinical and ward areas informed staff how to make referrals and who to contact.

Mandatory training

- The trust set an internal target of 85% completion for all staff groups for mandatory training in November 2015. For medical staff the overall training completion rate was 74%. Training completion rates for ethnicity and diversity was 80%, medicines management was 80%, infection control (nursing) was 78% and infection control (medical staff) was 58%.
- Statutory training completion for medical staff was 85% overall against a target of 75%. For safeguarding adults training completion was 88% and for safeguarding children training (levels 1, 2 and 3) training completion was 84%, 72% and 76% respectively.
- Data on Kilverstone ward indicated that 95% was the target for nurse mandatory training. Infection control (81%), blood transfusion (76%), basic life support (92%) and information governance (82%) all fell below this.
- Data from AMU showed that mandatory training was below target for a number of courses including diabetes inpatient care (49%), safe use of insulin (53%), safeguarding adults (90%) and children (86%) and moving and handling (70%).
- We spoke with 24 staff about mandatory training. All had completed some mandatory training recently but not all were up-to-date with all their mandatory training. Ward managers told us they were aware that not all mandatory training was up to date and that this was a priority.

- Six staff said they had had mandatory training cancelled because of insufficient ward cover to enable them to attend. Mandatory training was a mixture of face to face and eLearning modules.

Assessing and responding to patient risk

- Early warning scores (EWS) were in use across the medical wards. All records we reviewed showed that scores were completed correctly and that patients identified as requiring clinical review were appropriately escalated and reviewed.
- Whilst all the EWS we observed were completed correctly and patients appropriately escalated, a weekly self-assessment for Gunthorpe ward for 30/10/2015 showed that only 20% had been fully recorded. Elsing ward had 100% compliance for the same period. Data on Heydon ward for September 2015 showed only 50% of audited EWS score were correctly escalated. Where individual wards had failed to meet benchmark; an action plan had been implemented to address the shortfalls.
- EWS audit data showed that in May 2015 95% EWS had been completed correctly against a trust target of 90%. Audit data also showed that only 59% of patients had their observations reviewed at an hour and 89% at two hours. There was improvement on these figures in June and July but remained below trust target.
- We were concerned that there were delays in patients attending the acute medical units (AMUM and AMUL) were not always reviewed in a timely way. During our inspection we saw patients waiting for two hours in chairs by the ward reception waiting for a bed and clinical assessment. There was also one patient who waited for seven hours from time admission for a clinical review during our inspection. Senior staff confirmed this was the case. In 19 sets of notes reviewed in the AMU's, nine patients had not been reviewed by a consultant within twelve hours and one patient had not had an examination on admission.
- Senior medical staff stated that consultants reviewed patients between 8am and 5pm on the post take ward round. Patients admitted later than this were seen the following day which led to some patients waiting over 12 hours for consultant review in the acute medical unit.
- Health Education East of England found in July 2015 that patients were sometimes transferred inappropriately to Mattishall Ward without the inpatient teams being made aware of this.

Medical care (including older people's care)

- Mattishall ward is a short stay ward for medically stable patients who are expected to be discharged in 24 hours. There was guidance for ward staff about patient suitability for Mattishall ward and a checklist to ensure that appropriate patients only were transferred onto the ward. This included the patients having been recorded as medically fit for discharge in the notes.
 - We reviewed six sets of records for patients on Mattishall ward and found no evidence in the records that the patients' medical team had made an explicit judgement as to the patients' suitability to be cared for on the ward. We were told that on occasions, site managers overruled the transfer criteria to move patients through the hospital when under pressure for beds. Meeting minutes from June 2015 showed a further concern of a patient being transferred to the ward without appropriate review first in the AMU.
 - Data supplied by the trust showed that between 1 August and 31 October 2015, 68 patients had been transferred back to an acute ward rather than discharge. Other trust data showed that between June and October 2015, 81 patients had been admitted to Mattishall ward who did not meet admission criteria. We remained concerned that patients not suitable for care on Mattishall continue to be cared for on this ward.
 - There was a 24 hour, seven day a week acute stroke nurse service to support inpatients as well as those arriving at the hospital.
 - There was a patient safety handover on the stroke unit to ensure all at risk patients were appropriately identified and monitored.
 - There was no 24 hour critical care outreach service. Out-of-hours cover was managed by the site nurse/hospital at night team.
 - Audit data from January 2015 showed that in endoscopy, only 77% of patients had a fully completed checklist. An action plan had been put in place to address this.
- ## Nursing staffing
- A full nurse staffing audit took place each year using a recognised safer nursing care tool. Staff were aware this was carried out yearly with a safe staffing meeting monthly.
 - Nurse staffing numbers both planned and actual were clearly displayed at the entry to wards. A number we checked showed that they displayed accurate information.
 - Trust data for July 2015 showed that most wards were staffed to close establishment or better but some wards were understaffed. These included Holt ward where for trained nurses actual to planned ratio was 81% for March, 85% for May and 80% for June 2015. There had been a corresponding rise in health care assistants for May and June but not for other months. Unfilled required shifts was at 92% for June 2015. For the same measure Elsing ward had 86% for March, 82% for June and 87% for July 2015. Unfilled shifts were at 55% for June 2015. Brundall ward was 85% for May, 88% June and 87% for July 2015 with 48% unfilled shifts for July 2015.
 - There were a number of wards run on a very similar level of staff despite them being of different specialties and acuities. On four different wards staff told us that they felt acuity had changed but that an acuity tool had not been completed in response to this. Guist, Dunston, Coltishall, Kilverstone and Hethel ward all had the same or very similar planned staffing levels despite them being of different specialties (elderly care, cardiology, acute respiratory amongst others) with different levels of acuity.
 - Trust data showed there to be approximately 57.4 vacancies for registered nurses across the medical wards in July 2015.
 - The hyper acute stroke unit (HASU) comprised 12 beds. Current staffing on the date of our inspection was two registered nurses and one health care assistant. This fell outside of the Royal College of Physicians National Clinical Guideline for Stroke 2012 which states there should be 29 WTE staff per 10 HASU beds, split 80% registered nurses and 20% health care assistants.
 - Hethel ward had three patients on acute non-invasive ventilation (NIV) and six further patients on their own (chronic) NIV. Staffing for the ward was five registered nurses and four health care assistants for a total of 34 ward patients. British Thoracic Society guideline The Use of Non-Invasive Ventilation in the management of patients with chronic obstructive pulmonary disease admitted to hospital with acute type II respiratory failure states there should be a minimum of one registered nurse for every two patients on acute NIV in the first 24 hours of treatment. We were concerned that staffing on this ward did not meet this guideline or the specific acuity of these patients had not been considered.

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- Trust data showed that between January and November 2015 there had been 308 patient referrals to critical care outreach for respiratory wards (Coltishall and Hethel). This was the number of individual patients referred, not the total number of visits they received.
- There were vacancies on the AMUs. Staff told us that it could be a challenging environment in which to work but they had recently recruited six newly qualified nurses. Senior nursing staff were aware of the challenges this posed regarding skill mix and were addressing this with the use of 'buddy' staff and rota management. Staff were busy and on two occasions, inspectors had to find staff to assist patients who were not observed to need assistance. The senior nurse on at night also carried the overnight bleep for admissions from GPs etc. as well as coordinating the ward. A number of staff said this was a challenging part of the role. Records showed that on one night shortly before our inspection, the bleep holder/ coordinator answered 30 calls/ referrals in addition to coordinating the ward. Data supplied by the trust showed that frequent overnight referrals were a regular occurrence.
- Senior staff told us that Dunston Ward had a large additional spend on staff above establishment since April 2015 which was the highest in the hospital. This indicates a staffing establishment that does not meet the acuity of patients being cared for. Data provided by the trust put the additional agency and bank spending between April and November 2015 at just over 250,000 pounds of which approximately half was for providing one to one care. During our inspection we observed staff to be very busy, with 30 patients being bed bound, a large number requiring intravenous fluids and intravenous antibiotics as well as those with catheters. The ward had also recently admitted a patient with very complex needs. We received a complaint during the inspection from a relative of a patient on the ward who complained that the patient did not receive care and attention in a timely way.
- We immediately raised our concerns with the director of nursing to review the acuity of patients on the ward and the staffing establishment. On our unannounced inspection on 25th November there were additional staff working. Staff said that the acuity had reduced and that there was sufficient time to care for patients.
- There was frequent use of agency and bank staff on a number of the wards. Four agency and bank staff we spoke with told us they had been orientated to the ward and received a short local induction before commencing work. The endoscopy unit had used long term agency staff, three of them for a number of years. Whilst many wards had induction checklists for agency staff such as in the stroke unit, on other wards such as Dunston ward that there was no such checklist.
- Staff said that there were small numbers of unfilled shifts and rotas we reviewed on site showed that this was the case. In one set of notes, a patient was recorded to require one to one supervision but it was not provided as it had been "not covered". On Holt ward, on one day of our inspection, two additional staff to provide one to one care were not available.
- There was variable sickness rates across the division. Data from July 2015 showed sickness across the division was 3.18 and the lowest for some months. Sickness amongst administrative and estates staff was higher than this and above trust target. Wards with higher than trust target sickness absence for July 2015 included AMU (L) and (M), Dunston, Elsing, Endoscopy, Hethel and Heydon.

Medical staffing

- The trust had a higher proportion of consultants than the England average comprising 38% of the medical workforce compared to the England average 34%. There were slightly more middle grade and fewer registrars than the England average with a similar number of junior doctors as the England average.
- There were insufficient medical cover in some areas including the acute medical units. During our inspection there were 1.9 whole time equivalent (WTE) consultants for the AMUs against a planned 11WTE. The short fall was made up with locum cover but not always at consultant level. We were further concerned that the clinical director for the unit was not permanent but working on an interim basis.
- Health Education East of England had reported on 7 July 2015. Amongst other concerns, they noted that there were insufficient medical consultants in the AMUs and that the absence of a formal handover (due to staggered starting and finishing times) posed a risk to patient care. It was not evident that the trust had taken any action to address this following the report and trainee's reported finding the workload very high in these areas with inconsistent handovers.

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- Trainees stated that they regularly worked night shifts and rotas confirmed this. We found that six people were currently covering eight posts on the rota. There were vacancies in other medical specialities for junior staff including oncology and haematology.
- Health Education East of England had reported on 7 July 2015 and found concerns with the hospital at night team handing over to day staff which was inconsistent.
- In the stroke service, a consultant was on call for thrombolysis. Patients received a registrar review every day and a consultant review twice weekly on a full consultant rota.
- In the majority of clinical areas, consultant medical staff reviewed patients twice weekly, with registrars reviewing patients on a daily basis.
- Locum consultants were well supported by other senior medical staff and worked in cohesive teams.
- There were clear on call arrangements out of hours for consultant staff. For example, in cardiology there were interventional cardiologists on call for the catheter labs and non interventional on call for other patients.
- On call arrangements for senior training doctors (registrars) were clear and covered ward and emergency areas. Rotas showed sufficient junior medical staff to cover ward areas out of hours.
- Junior staff felt well supported in their work and had no problems getting on-call staff to review patients when required.

Major incident awareness and training

- There was a major incident and business continuity plan in place for the management of the medical division in case of one of these events.
- Staff on an acute medical unit were aware of the process they should instigate in the event of a major incident being declared. More junior staff were aware they might be called on the event of a major incident.

Are medical care services effective?

Good



We rated medical services effectiveness as Good because:

- Care given was in line with national guidance and best practice. Staff adhered to local policy and procedures and the trust took part in numerous national and local audits.

- Pain relief was given in a timely way and patients assessed for the effectiveness of the pain relief given.
- Patients received adequate nutrition and fluids and were supported where needed with other forms of nutrition.
- Patient outcomes were positive, the endoscopy unit was JAG accredited and risk of readmission was better than the England average.
- Staff were competent to carry out their roles and there was effective multidisciplinary working within medical services.

However, we also found:

- Staff had a limited understanding of the Mental Capacity Act 2005 and their responsibilities under it. There appeared a low number of DoLS applications for medical services.
- Appraisal rates were low in many clinical areas.

Evidence-based care and treatment

- Patient care pathways followed National Institute for Health and Care Excellence (NICE) guidance. The stroke pathway and treatment plan through the hyper acute stroke unit (HASU) into the acute stroke unit followed CG68 with good performance for time to diagnosis and treatment as demonstrated by audit (SSNAP).
- Pathways for patients having a heart attack were in line with national NICE guidance (CG167) and rehabilitation (CG172).
- There was clear evidence of ongoing local audit activity within the trust. A full audit plan was in place with lead clinician identified. The audit programme covered all specialities within the division and ran to near 100 local audits.
- One of the consultant cardiologists functioned as clinical governance lead supported by an audit facilitator.
- There was local audit activity including in cardiology that undertook regular pacing audits and stroke that completed internal audits alongside Sentinel Stroke National Audit Programme (SSNAP) using an electronic system called Capture Stroke.
- The trust had registered to take part in the National Cardiac Rehabilitation Audit and carried out an audit of initiation on Atorvastatin 80mg for patients admitted

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with Acute Coronary Syndrome which showed that almost half of patients (from a small sample of 26) were not initiated as recommended by NICE guidance. Further actions were identified on the basis of this audit.

- East of England (EoE) audit of primary percutaneous coronary intervention (PPCI) was undertaken reviewing records from 2014. This showed that the rate of call to balloon time in less than 150 minutes was 88% with 96% of patients seen within 90 minutes when attending the centre. This represented a small improvement on the service previous performance and in line with other local centres.
- Other audits being undertaken included Norfolk and Norwich Pacemaker and Implantable Cardioverter-defibrillator (ICD) Audit, Mineral and Bone Disease Audit and audit of dialysate potassium concentration amongst many others.
- Audit data for 13 patients receiving acute NIV showed that the appropriate assessment of the patient's pre-morbid state has been made by a doctor competent in initiating NIPPV on nine records only with only 57% patients' blood gasses being monitored at six hours.
- Local stroke audit data showed that the proportion of stroke patients admitted to the stroke ward in four hours was 77%, 94% had a brain scan in an hour and door to needle time for thrombolysis was 87% inside target time. All data was for September 2015.
- The integrated care pathway for endoscopy included the use of national guidance and evidence based practice.
- Wards carried out local quality audits that alternated on focus but recent examples included nutrition and hydration, dignity and respect, complaints and use of equipment.

Pain relief

- Pain scores were completed for patients requiring analgesia, both before and after administration.
- An acute pain team was available during working hours to review patients requiring analgesia. Out of hours this was the responsibility of the on call anaesthetist.
- Pain relief was available in a number of ways including orally, by injection and, for some patients who could not tolerate oral medicines, by syringe driver.
- 14 medicines charts we reviewed showed that pain relief had been given in a timely way in line with the prescription.

- We spoke to five patients about pain relief. All told us that they had appropriate pain relief when they had asked for it or been assessed for it.

Nutrition and hydration

- Patients had their nutritional status assessed and were referred to a dietician where necessary. All the malnutrition universal screening tools reviewed were completed accurately and updated to reflect patients' changing needs. Patients were prescribed nutritional supplements to enhance their wellbeing where required.
- Audit results showed that in most wards, malnutrition screening tools scores were well completed.
- Patients that required regular weighing were weighed at appropriate intervals and any action required taken in relation to their weight. This included referral to dietitians and other specialist staff.
- We observed patients being assisted with their meals when they were identified as needing help. Staff had a good knowledge of patients that needed assistance and ensured they were helped in a timely way. A meal coordinator was identified on each ward to ensure patients were properly supported.
- Patients who were unable to take nutrition and hydration orally were supported with intravenous fluids and other forms of delivering nutrition, for example through nasogastric (NG) tubes or percutaneous endoscopic gastrostomy (PEG).
- The dietician on Guist ward informed us that they worked closely with staff on the wards and in the catering department to meet patients' specific dietary needs.

Patient outcomes

- The trust took part in the National Diabetes Inpatient Audit in 2013, and performed above the England median in 15 of the 21 measures.
- The trust takes part in the Sentinel Stroke National Audit Programme (SSNAP). Norfolk and Norwich University Hospital showed an overall score of C in October to December 2015 Since the period January to March 2014, there has been evidence of improvement, with no scores below C in the last two quarters of 2014 with a good proportion of A and B scores.

Medical care (including older people's care)

- The trust took part in the 2012/13 Heart Failure Audit. The trust had good results overall, scoring above the England average for all but three of the indicators (two discharge practice indicators and one relating to receipt of echo).
- The trust had good results in the 2013/14 Myocardial Ischaemia National Audit Project (MINAP) audit, measuring the care of patients with non ST-elevation infarction (nSTEMI). The audit found that 100% of patients were seen by a cardiologist or member of team, compared to 94% in England. Fifty eight per cent of patients were admitted to a cardiac unit or ward, compared to an England average of 56%. Seventy nine per cent of patients were referred for or had an angiography, compared to the England average of 78%.
- The trust participated in the National Diabetes Inpatient Audit (NaDIA).
- The endoscopy suite had been accredited by the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) in January 2015.
- The standardised relative risk of readmission for medical services at the Norfolk and Norwich hospital were below the England average for both elective and non-elective (emergency patients) for specialties including general medicine, geriatric medicine, cardiology and gastroenterology.
- We spoke with 20 members of staff about appraisals. All had an appraisal in the past but eight told us that their appraisal was overdue or had not been completed in the last year.
- Staff undertaking extended skills such as the administration of chemotherapy were assessed using a competency assessment tool following any training required.
- In coronary care, all senior nurses had undertaken the coronary care course and updated regularly. There was always a senior member of staff in coronary care. Training records showed this to be the case.
- Clinical educators supported new and experienced staff in maintain and developing new skills and helped ensure new staff were properly supported and inducted.
- Staff in endoscopy were mentored for six months. Depending on an assessment of competence they were then placed 2nd on call on the on call rota so they would have support if they were called in.
- Nursing staff working in stroke services were rotated through the stroke wards (Heydon and Gunthorpe) as well as the hyper acute stroke unit (HASU) to maintain and update skills.
- Medical staff were revalidated in line with trust policy and GMC requirements.
- Nurse specialists worked across the directorate to support specialist care and staffing caring for complex patients. Competency assessments were in place for staff undertaking advanced skills such as chemotherapy administration and that these were reassessed on an ongoing basis.
- Training medical staff spoke positively about their training rota, that it gave sufficient support and exposure to their training needs.

Competent staff

- We were told that all new staff attended induction training and 11 staff including medical and nursing staff confirmed they had received adequate induction. One agency member of staff confirmed they had received an induction into the area they were working in.
- We reviewed an induction file that showed key competencies' were considered and that staff had meetings with their supervisor and manager.
- Two staff told us that there were no formal systems in place for regular supervision sessions with their line managers, but issues raised on a need based basis.
- One staff member told us they received annual appraisals, one senior member of staff said they hadn't had an appraisal in two and a half years, information provided by the trust indicated that appraisal figures for the medicine specialties were at 65% in June 2015. Kimberley ward had a 100% and Kilverstone 70% appraisal completion rate in November 2015.

Multidisciplinary working

- Staff described good, collaborative working practices with a range of allied health professionals. There was generally a joined-up and thorough approach to assessing the range of patients' needs, and a consistent approach to ensuring assessments were regularly reviewed and kept up-to-date.
- Most wards undertook a daily board round where the multidisciplinary team including nurses, doctors, therapists and discharge coordinators discussed the plan and needs of patients.
- We attended a multidisciplinary meeting that was a well-managed meeting and enabled staff to share

Medical care (including older people's care)

detailed information regarding patient wellbeing. The multidisciplinary team discussed a patient's adult end of life (AEoL) care and there were clear links to other specialist staff that would provide further AEoL support. The MDT included staff from the hospital as well as external staff such as social workers.

- Therapy staff told us that they felt part of a strong MDT and their views and opinions valued. All staff described cohesive teams working well together.
- We observed numerous interactions between members of the MDT. All were positive and clearly showed mutual respect.
- There was joint working with a community health trust to identify patients awaiting discharge. These staff would review every patient awaiting a rehabilitation bed and attended two board rounds weekly.
- There were regular regional MDT's for complex patients to discuss treatment plans and ensure patients received the most appropriate, individualised treatment.
- One community nurse who had come in to assess a patient told us they had been kept informed of the complex discharge and their opinion sought early to ensure a full MDT plan was in place for the patient's discharge.

Seven-day services

- There was a formal on-call rota for emergency endoscopy procedures out of hours. Staff were fully aware of how to request the on call team who all lived within a short distance of the hospital. There were endoscopy lists at weekends as well as a small number of lists for evenings.
- The transient ischemic attack (TIA) clinic based on the AMU was not a seven day service with staff unable to get Doppler assessments, to monitor blood flow, over weekends.
- Physiotherapy staff worked weekends including on the stroke unit where new patients and patients being discharged were reviewed. There was an on call chest physiotherapist available at all times.
- There was no seven day occupation therapy (OT) service. The stroke unit had four hours of OT cover on a Saturday but none on a Sunday.
- PPCI was available for emergency patients but there was no regular catheter lab list or capacity over weekends. Catheter lab capacity was a recognised concern and on the division risk register. There was a recruitment plan for seven day working in the catheter lab.

- The speech and language therapy team did not run a seven day service. Senior managers were aware of this but there were no plans to address this.

Access to information

- Patient records were readily available on admission or brought with them from the emergency department. Staff said that medical records occasionally "went missing" on transfers between hospitals but we found no incidents reported of this.
- Investigation and test results were available via an electronic pathology system. Staff told us they had access to results promptly.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- At our inspection in March 2015 we found that staff on the AMU had a poor understanding of the Mental Capacity Act.
- Staff stated they had completed mental capacity training as part of safeguarding training. We spoke with 11 staff about the Mental Capacity Act 2005 and capacity assessments. Three members of staff had a good knowledge of the Act and their responsibilities. Other staff gave a variety of responses and seemed unclear about their responsibilities under the Act. Two members of staff spoke about the Mental Health Act in error, mistaking it for the MCA and two further staff told us they believed it was a doctor's responsibility to carry out the assessments though all staff had a responsibility under the Act. A fifth member of staff was not able to identify who to contact if they needed support with completing a MCA assessment.
- Four sets of records we reviewed and indicated that the patients were "muddled" or confused yet no mental capacity assessment had been completed. On each occasion we brought this to the attention of the most senior nurse on the ward.
- We saw three Deprivation of Liberty Safeguards (DoLS) assessment and checklist properly completed. On one ward a patient was receiving one to one care because they were confused but there was no evidence a DoLS assessment had been considered for this patient.
- Trust data showed there had been 26 DoLS applications made for all medical wards between April and November 2015. We were concerned that this seemed a

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small number particularly given the variable understanding of staff of the Mental Capacity Act. In comparison another provider of similar size had 36 applications within an eight week period.

- We observed verbal consent being taken from a patient prior to an emergency procedure. Three records we reviewed with specific consent forms showed them to be appropriately completed with risks and benefits clearly identified.

Are medical care services caring?

Good



We rated caring as good because:

- The NHS Friends and Family Test (FFT) scores were generally very positive for medical wards with the exception of the AMUL.
- We observed many examples of staff delivering compassionate care to patients and their relatives and carers.
- Patients told us they were actively involved in planning their treatment and were given options where possible.
- Patients' emotional needs were met either in the hospital or were referred for ongoing care.
- The trust measured call bell response times.

Compassionate care

- Response rates for the Friends and Family Test were 8% lower than the England average at Norfolk and Norwich University Hospital. However, in most wards, over 90% of patients said they would recommend this service.
- There had been poor results from patients for the Friends and Family Test (FFT) in the Acute Medical Unit (M) of 72%. For AMUL the latest FFT for September 2015 was 64%. The majority of the issues raised were around waiting times.
- Friends and Family results were clearly displayed on the information board at the entrance of the Wards. Most results displayed were positive, for example on Guist ward FFT for October was 95%, 97% for Coltishall ward and 96% for Kilverstone.
- Coltishall ward had won the Ward of the Year award 2015, for their dedicated multidisciplinary working, and going above and beyond to ensure patients, relatives and staff felt well informed and cared for.

- Staff were observed delivering compassionate care on all medical wards, and responding to patients' needs. On Langley ward staff were observed ensuring patients were positioned correctly prior to lunchtime, and handing patients hand wipes to clean their hands.
- On Langley ward we spoke with three patients and one relative. All said that they could not fault the care provided by the nursing or medical staff, and understood their plan of care. Those spoken to all commented on how short staffed the ward appeared to be.
- In all ward areas staff pulled curtains around each patient's bay and closed doors to maintain patients' privacy and dignity. All curtains displayed a sign reminding staff of maintaining dignity.
- A number of wards had photographic scenes placed within the ward, which could trigger memory to patients living with dementia or cognitive impairment
- On Kimberley ward we observed a physiotherapist supporting a patient to walk using a walking frame in order for the patient to carry out their own personal care. The patient interaction and support with the therapist was excellent; they promoted privacy and dignity, and the patient managed their own care.
- The trust monitored call bell response times. In the latest available data from the nursing quality dashboard showed that for day time response to call bells AMU (L) and (M), Hethel, Heydon, Holt, Langley and Mulbarton wards all missed the trust target of 2.5 minutes in July 2015. On some wards the wait was longer than five minutes.

Understanding and involvement of patients and those close to them

- There were initiatives within the medical wards to ensure that there was involvement with patients, carers and families.
- 14 patients told us they had been involved with their care planning and options in treatment given where possible.
- On Heydon ward there were clear processes in relation to early contact with the patient, family or carer following stroke, with early contact made and an initial multidisciplinary meeting arranged.
- We were advised that family or carers could stay with patients who were nursed in a side room and that visiting times were flexible.

Medical care (including older people's care)

- We observed one set of relatives being asked to wait outside the ward for a few minutes, before the official visiting time had commenced.
- On Elsing ward we observed a discharge coordinator providing advice and support to a relative, who appeared anxious. We observed that the discharge coordinator provided reassurance to the relative.
- Elsing ward had recently developed a ward newsletter for patients, family and carers, which provided updates and advice. The ward also ran ward parties, four to five times per year for patients, families and carers to come together in a therapeutic environment. We were advised that there were plans for the development of a designated garden area and a dining area within the ward.
- Early contact was made with relatives of patients who had had a stroke so that a full multidisciplinary team (MDT) meeting could be arranged in which patient, family (carers) and MDT met together to look at diagnosis, plan of care and discharge requirements.

Emotional support

- We visited the renal unit, which provided literature to patients, families and carers, in relation to accessing holiday support and guidance for renal patients wishing to take a holiday. Patients had access to a dedicated social worker and a counselling service for emotional support.
- A clinical psychologist was based on the stroke unit to assist patients in the acute phase of their illness.
- Staff signposted patients for continued support such as that provided by the Stroke Association.
- We reviewed one record where a patient had been referred to counselling services for ongoing care and treatment.

Are medical care services responsive?

Requires improvement



We rated responsive in medical services as requires improvement because:

- The ambulatory care service on the acute medical unit did not have ring-fenced beds and was regularly used as

inpatient beds. This meant ambulatory care was either restricted or suspended on a regular occasion with patients having to attend the AMU separately or the emergency department.

- Discharge arrangements and plans were not always clear.
- Patients regularly had to wait in a public area whilst awaiting a bed on the AMU. This was either on chairs or ambulance trolley's and could be up to 2.5 hours.
- 121 patients were in hospital for more than 60 days between May and October 2015.
- We were concerned there was a mixed sex breach on the AMU (M) ward.
- There was not enough specialist chairs on Dunston ward for patients to be able to sit out of bed.

However, we also found:

- There was an excellent primary percutaneous coronary intervention PPCI service for patients with cardiac symptoms.
- Medical services were meeting referral to treatment times.
- On Elsing ward we observed that the bays had been colour coded to assist patients moving around the ward and single use knitted sensory bands. Holt ward had refurbished a room to 1950's décor.
- There was evidence of learning from complaints.

Service planning and delivery to meet the needs of local people

- The trust had significantly developed its primary percutaneous coronary intervention (PPCI) service to offer a very responsive pathway to patients. Close working with the local ambulance service meant potential patients were identified by paramedics who alerted the service. Patients were met at the door by a senior doctor or nurse, consent taken and medical history and then immediately into the catheter lab (when not in use).
- During our inspection one patient was admitted using this pathway. Door to catheter lab time was four minutes with the procedure starting shortly afterwards. National audit data showed this to be a very responsive service.
- There were plans in place for a purpose built centre for endoscopy being progressed in conjunction with a number of partners.

Medical care (including older people's care)

- There was a dialysis trained nurse on the inpatient ward which meant that inpatients requiring dialysis did not have to be transferred to the day unit.

Access and flow

- The trust met the 90% Referral to Treatment Time (RTT) target between April 2013 and August 2014, and between November 2014 and May 2015 (with the exception of February 2015). Between April 2013 and May 2015, all medical specialties (cardiology, dermatology, gastroenterology, geriatric medicine, neurology and rheumatology) met the standard.
- Trust data for August 2014 to July 2015 showed that 75% of patients did not move ward during their admission with 18% moving once. 1% moved four or more times. There was no data specifically for medical wards.
- Average length of stay for elective patients was overall lower than the England average though gastroenterology and clinical oncology were slightly above the England average. Average length of stay for non-elective (emergency) patients was overall just lower than the England average.
- The trust had identified an issue with waiting times for some endoscopy procedures and had contracted a private firm to provide weekend endoscopy procedures to reduce waiting times and offer convenient times to patients. We asked for a full profile of patients awaiting endoscopy but received a limited data response regarding cystoscopy which showed 46 patients awaiting the procedure.
- Data from the monthly divisional quality report showed a total of 1406 patients awaiting a gastroscopy, sigmoidoscopy or colonoscopy in June 2015. All these specialties had increased demand on the previous month and on an upward trend. Senior division managers told us there had been a significant increase in demand for endoscopy in the preceding 12 months.
- Ambulatory care assessment was carried out in AMUM. Staff told us that there were four beds assigned for this with a small waiting room for patients awaiting assessment. However, these beds were not ring-fenced. During our inspection the beds were routinely occupied by inpatients and, on one occasion, all four beds were occupied by inpatients. Staff told us this was a common occurrence. We observed that ambulatory care was not able to commence on that day as there were no beds available for assessment.
- During our inspection we regularly saw people waiting and queuing for a bed in the AMU's. This included one patient being admitted for dysphagia who waited two hours for a bed and had only their observations completed in that time. Three ambulance trolleys also queued during our inspection. These patients had to wait in armchair or trolleys by the nurse's station at the entrance of the ward which offered no privacy and little comfort. Visiting professionals told us it was usual to wait with a patient on a trolley. Data provided by the trust showed that average time for GP patients booking in to being given a bed was two and a half hours.
- Average length of stay on AMU (M) and (L) was approximately a day and half before being discharged or being moved to a ward.
- Length of stay was 2.7 days for elective patients and 6.6 days for emergency patients.
- There were regular bed meetings held three times a day to manage capacity. The on call executive regularly attended these meetings.
- The hospital admitted from other local hospitals for emergency cardiac intervention (PPCI) which was coordinated via an electronic system. This allowed staff to monitor patients in other hospitals and prioritise care and treatment.
- On four wards, staff told us that anticipated discharge dates were not always completed by consultants and were completed by senior nurses "as and when". This indicated a lack of focus on patient flow and effectively managing discharge.
- Staff told us that there were some delays in discharging patients due to slow continuing healthcare assessments.
- There was joint working with a community health trust to identify patients awaiting discharge. These staff would review every patient awaiting a rehabilitation bed and attended two board rounds weekly.
- Discharge coordinators were assigned to wards to support and facilitate discharge.
- Outliers were readily identified and patients seen by the appropriate medical team. In stroke services one consultant was dedicated to look after outliers.
- Data supplied by the trust showed that between May and October 2015, 121 patients were in hospital 60 days or more before discharge.

Medical care (including older people's care)

- Dedicated acute oncology nurses were available at weekends to reduce door to treatment time for neutropenic sepsis. Audits showed this to be a responsive service.

Meeting people's individual needs

- We were concerned that there was mixed sex breach on AMU (M). On this otherwise male ward, a bay for female patients had been created. Staff encouraged the ladies to use commodes but if they wished to use the toilet they had to walk out past a male bay and side rooms to the toilet. According to trust information, no single sex breaches had been reported.
- There was a dedicated consultant in the stroke service for thrombolysis so that patients requiring this treatment were seen and treated promptly. Audit data confirmed the responsiveness of this service.
- Patients living with dementia and those who had suffered stroke had "This is me" documentation in place. The division had dementia strategy and delirium strategy in place and were supported by a dedicated dementia team.
- Patients who had had a stroke were seen promptly by speech and language therapy (SaLT) to reduce the time patients spent nil by mouth. Records reviewed showed a prompt review by SaLT in line with audit data. Patients had a key worker in stroke services who led on arranging multidisciplinary team meetings etc.
- A dementia support team assisted ward staff with expertise in how to care for patients living with dementia.
- In response to a Friends and Family Test response in relation to noise at night, ear plugs had been purchased for patients and bins replaced as the soft close facility had broken on many of them.
- On Elsing ward the bays had been colour coded to assist patients moving around the ward and single use knitted sensory bands
- Holt ward had recently refurbished their day room to a nostalgic fifties style lounge area. This was to enable patients living with dementia or cognitive impairment to reminisce and engage in activities such as dominos or listen to music.
- On Dunston ward a large number of patients were receiving care in bed. Physiotherapy staff told us that they had four Delta (a specialist positioning chair) chairs for patients on the ward but there were 10 patients that

would be able to sit out of bed if there were more available. A sample of moving and handling assessments checked indicated that some patients would be able to sit in a supportive chair.

- In some clinical areas, relatives were able to stay with patients. There was an example of a complex patient who had a stroke and whose relatives were able to stay with and support them.
- Staff had prompt access to specialist equipment including bariatric and pressure relieving equipment.

Learning from complaints and concerns

- Staff were able to tell us how they managed complaints locally or who to refer patients to if they wished to make a formal complaint.
- Staff were able to tell us about the most recent complaints in their clinical area and any themes arising from the complaints. They told us that they had received feedback about the complaints and any changes in practice. We observed meeting minutes which described learning from complaints and identified a change in practice following a breach in patient confidentiality during ward handovers.
- We reviewed two recent complaints which had been investigated appropriately and an outcome identified. The report also considered whether the complaint may trigger the duty of candour requirement.

Are medical care services well-led?

Requires improvement

We rated medical services as requires improvement for well led because:

- Staff were aware of the trusts vision and strategy but were unsure of the divisions or clinical strategy. Senior staff told us they were concerned there was not a strategy for managing over the winter. There was no clear strategy for the management of the AMU or ambulatory care.
- We had identified concerns on Mattishall ward in March 2015 as had Health Education East of England in July 2015. Despite improvements it remained a suboptimal area for patient care with a large number of patients not meeting its admission criteria placed there anyway.

Medical care (including older people's care)

- A senior member of staff responsible for a number of wards was unable to discuss with us staffing arrangements on their wards. They told us they were not best placed to discuss staffing and that should be the ward manager.
- Root cause analysis reviews were poorly completed. Whilst mortality and morbidity was clearly discussed as specialism level, there was no evidence of how relevant learning could be shared with other specialisms.
- There was only interim clinical leadership in a very busy and key department which had already seen a number of changes in the preceding 12 months.

However, we also found:

- Staff spoke highly of their immediate managers and there were a significant number of enthusiastic junior staff and matrons who were passionate about good patient care.
- Staff told us that the culture was open and transparent and that they felt able to report incidents or concerns.
- The new executive team were actively listening to concerns and staff were positive about the change in leadership.

Vision and strategy for this service

- Senior staff told us they were concerned that there was no plan or strategy for the acute medical service over the winter. Senior managers told us that there was not much flexibility in the AMUs because of how busy the ward had been but "that they were a good bunch of staff". Senior division managers confirmed there was a winter plan which was being evaluated by Monitor.
- Senior divisional staff were positive about the future citing a good, cohesive team
- The majority of staff on wards and clinical areas were unaware of a local vision or strategy but could articulate the trust vision and strategy. The trust vision was clearly visible around the hospital and medical wards.
- During our March 2015 inspection we had been concerned about the environment on Mattishall ward and the plan for the future of the ward. Since that inspection the ward had been due to close in August and then October 2015 but this had not happened. There was now a plan in place to keep the ward open and open it fully as an endocrinology ward. Some refurbishment work had been undertaken to make it fit

for purpose as an acute inpatient ward but full refurbishment was not due to be completed until May 2016. The ward was improved but remained a suboptimal environment for caring for patients.

Governance, risk management and quality measurement

- The division risk register was up-to-date and risks were clearly identified along with their mitigation.
- Two root cause analyses (RCA) we reviewed were poorly completed and did not identify a true root cause. Four senior staff told us they contributed to RCA but that they had not received training in completing RCA. Ward managers on a number of wards told us that they did not have regular finance meetings to understand the performance of their ward.
- Meeting minutes showed regular governance meetings across the division. We reviewed minutes for cardiology and neurology governance meetings which covered mortality and morbidity within the service, outcomes of complaints, case discussions and audit data/ results. However, it was not clear how learning would be shared between specialities in the event of a wider learning need.
- There was a regular division quality dashboard outlining main quality indicators including infection rates, serious incidents, number of new risks and RIDDOR notifications amongst many others. A nursing dashboard was produced monthly with key performance and quality indicators for all wards in the division. This was followed up with action plans where necessary.

Leadership of service

- Most staff felt well supported by their immediate managers. A number of senior staff told us they had not felt supported by some members of the executive team, one example being in relation to help with staffing issues.
- Staff were supported when moving into leadership roles. Two new ward leaders told us they had been supported by their managers and matron's in taking leadership responsibility.
- Staff in clinical areas told us they did not think that the senior executive team were visible in clinical areas.
- Senior staff had a good understanding of the concerns of junior staff, such as vacancies, and were addressing these concerns. The matron responsible for Mattishall

Medical care (including older people's care)

ward had a clear understanding of the risks associated with that ward area and was actively managing the move to full refurbishment and had employed a substantive ward manager.

- A senior member of nursing staff responsible for the management of several wards was not able to discuss staffing on a particular ward and said that they were not up to date with the situation and we should instead speak with the ward manager.
- Senior staff were sighted on the concerns related to Mattishall ward but there had been delays in refurbishing this ward and repurposing it as an endocrinology ward. Senior managers were aware of the pressure AMU was under and the need to recruit medical staff. However, ambulatory care was functioning poorly or, on some days, not at all and trainee medical staff spoke of frequent night shifts.
- The matron newly responsible for Mattishall ward had a clear understanding of the risks associated with that ward area and was actively managing the move to full refurbishment and had employed a substantive ward manager.
- We were concerned at the high number of vacancies in the acute medical unit for consultant medical staff. The busy unit was led by an enthusiastic clinical director but they were in an interim position. There had been a number of changes in clinical leadership on the unit in the preceding 12 months.

Culture within the service

- Staff told us that the culture in the service was open and transparent. Staff felt able to raise concerns but they were not always confident things would change if they raised concerns.
- Staff were proud to work in their areas and were enthusiastic about service development. A number of junior staff had ideas to improve services and care for patients.

- Staff told us they felt valued by their managers. There had been changes in the executive team in the months before our inspection. We were told it had been an unsettling time but that it had started to settle.

Public engagement

- Some clinical areas including Elsing ward had ward newsletters available for patients, relatives and staff. Two patients who had regularly received newsletters said they found them interesting and informative.
- The trust sent out regular information to members of the foundation trust seeking views of members.

Staff engagement

- Minutes showed that most wards held regular ward meetings. Ward managers however said that it was not always easy to arrange meetings and a number had developed other ways of communicating such as through newsletters, bulletin boards or briefings before the start of a shift.
- The new executive team held a number of listening events so that staff could voice concerns, ask questions or offer ideas for the development of services or change to working practices.

Innovation, improvement and sustainability

- Clinical reporting and scheduling system in cardiology (Intellect) has been developed locally allowing the service to be more coordinated and efficient.
- Stroke care offered a responsive service with good outcomes.
- There was an excellent primary percutaneous coronary intervention (PPCI) service which provided prompt, effective treatment in line with national guidance and demonstrated good working with other providers and professionals.

Surgery

Safe	Requires improvement	
Effective	Good	
Caring	Good	
Responsive	Requires improvement	
Well-led	Requires improvement	
Overall	Requires improvement	

Information about the service

Norfolk and Norwich University Hospital NHS Foundation Trust provides a range of surgical services including general surgery, elective and trauma orthopaedics, ear, nose and throat (ENT), urology and vascular. The trust undertook 55,375 spells from the population catchment area of approximately 614,000 people. 3,700 of these were undertaken at Cromer Hospital where day surgery was undertaken.

The service has 10 surgical wards at the trust comprising, 338 inpatient beds, 26 day-case beds and 28 operating theatres. The service also has a surgical assessment unit which we also inspected. We inspected all wards, the surgical assessment unit, the day surgical ward and a sample of the theatres undertaking both inpatient and day case surgery. We also inspected services at Cromer hospital which has two theatres undertaking a variety of surgical specialties including ophthalmology, dermatology, urology and gynaecology. All surgery at Cromer is under local anaesthetic, with no provision on site for more complex procedures that require general anaesthesia or sedation. There is no provision on site for overnight admissions.

During this inspection, we spoke with 65 staff, including medical and nursing staff, 21 patients and seven relatives. We reviewed 36 sets of medical records and information requested by us and provided from the trust.

Summary of findings

Surgery services were rated as 'requires improvement' overall. Safe, responsive and well led were rated as requires improvement with effective and caring rated as good.

Incidents and learnings from serious incidents were not communicated in a timely manner between the Cromer and Norwich sites. Communication was identified as a concern and often changes to clinical practice at Norwich were not reflected at Cromer.

Nurse staffing did not reflect the patient acuity and patient care was impacted by delays to care and medications. There were 33 vacancies across the service, registered nurse hours were frequently replaced by healthcare assistant hours. Staff reported being discouraged from using the electronic incident system to raise concerns about staffing shortages due to the time taken to investigate these incidents.

Five of the nine surgical specialties did not meet the 90% standard of the proportion of patients waiting less than 18 weeks from referral to treatment. The proportion of cancelled operations which were not rebooked within 28 days has also been worse than the England average since April 2013. There was a good discharge service on some wards and ward to ward transfers did not frequently occur after 10pm. The service monitored the use of its theatres to ensure that they are responsive to the needs of patients. The service

Surgery

had opened the day case theatre on Saturdays to elective cases to meet the needs of local people and a new vanguard theatre was under installation to reduce the number of patients awaiting surgery.

Cromer hospital provided numerous one stop clinics for cataract surgery and urology. This meant that patients could be seen and treated in one appointment to improve patient experience and reduce delays.

The storage of patients' medical records was not secure however most records reviewed were generally well completed.

Mandatory training completion rates were just below the trust's internal target and appraisal rates were below trust and national levels.

Ward areas were visibly clean, with appropriate equipment and facilities for hygiene and infection control, but hand washing and decontamination processes were found to be inconsistent. Equipment was available to staff and had been serviced and checked in line with policy. Medicines were stored securely and appropriately although on the surgical assessment unit the ambient temperature of the room where medications were stored had exceeded the temperature recommended but no actions had been taken to ensure the efficacy of the medications.

Multidisciplinary attendance on ward rounds and ward meetings was generally good. . Three wards had access to a dedicated pharmacy lead and staff were able to access specialist support from a pain management team and a safeguarding lead.

Induction and competency assessments were in place for bank and agency staff and there was an attempt to use regular agency staff. However, locum and agency staff did not have access to the computer system and could not request or review information as a result.

The majority of patients and relatives said that nursing staff were caring and helpful and that staff treated patients with dignity and respect. However, patient feedback on their understanding and involvement in their care was mixed. Handling of patient complaints was not consistent across all areas.

There had been a change in the leadership team and whilst some staff felt that the culture had started to

improve others reflected and staff morale was still low within the surgery division with staffing and clinical pressure a contributing factor. Local leadership was good however visibility of the senior team across all areas was varied and response to issues highlighted was not actioned or responded to in a timely manner. There was a lack of managerial support for senior staff at Cromer hospital.

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Are surgery services safe?

Requires improvement



We rated surgery services as 'requires improvement' for safe because:

- The effectiveness and timeliness of communication between the Cromer and Norwich sites was identified as a concern, particularly in relation to lessons learnt and changes to clinical practice.
- There were no local audits or measurement of the quality of the World Health Organisation (WHO) checklists at either Cromer or Norwich sites.
- Staff reported being discouraged from using the electronic incident system to raise concerns about staffing shortages due to the time taken to investigate these incidents.
- There was inconsistent use of handwashing and decontamination processes.
- The storage and security of patients' medical records was not robust.
- Nurse staffing did not reflect the acuity of patients on the ward. There were a high number of vacancies and registered nurse gaps were frequently filled with healthcare assistant hours.
- Staffing shortfalls impacted on patient care and delay with medication.
- Processing of flexible endoscopes was not undertaken, monitored or recorded appropriately to ensure patient safety and minimise the risk of infection.

However,

- Incidents were reported and staff were knowledgeable about the process.
- Ward areas were visibly clean, with appropriate equipment and facilities for hygiene and infection control.
- Equipment was available to staff and had been serviced and checked in line with policy.
- Medicines were generally kept securely, stored correctly and recorded appropriately.
- We checked 18 patient records and found that they were in general well completed.
- There were clear processes and procedures in place for safeguarding and relevant staff training was up to date.

- Systems were in place to assess and respond to patient risk.
- Locum cover for surgical staff was low and junior doctors felt well supported with sufficient medical staff available at all times.

Incidents

- The trust reported 30 serious incidents between August 2014 and July 2015, including 16 pressure ulcers and six slips, trips and falls.
- A system and process for reporting of incidents was in place. Staff understood the mechanism of reporting incidents, this was confirmed verbally, both at junior and senior level. The incident reporting form was accessible via an electronic online system. Staff received information on outcomes from incidents from the matron at ward meetings.
- Whilst many staff were aware of the process for reporting incidents through the electronic system they had been discouraged from using this system for raising concerns regarding staffing shortages. Staff stated that this was because reporting these on the electronic system was creating too many incidents which took time to address.
- The trust had introduced a NICE recommended red flag system (excel spreadsheet), with a supporting approved staffing guideline which monitored and documented staff shortages, and dictated required actions. This was completed to "flag" where staff had concerns over staffing levels and was reported to trust board each month. Staff said that they had seen no impact from reporting shortages of staff on either system.
- Communication of lessons learnt from incidents between the two sites, Cromer and the Norfolk and Norwich hospital, occurred through the divisional board meetings for surgery but was not always effective. There had been two serious incidents reported as never events (a never event is an incident so serious that it should never happen) in ophthalmology that occurred, one at both sites, within six months of each other. Both involved wrong site surgery by an injection undertaken into the incorrect eye. The never event incidence was flagged as a risk in the CQC May 2015 intelligent monitoring report.
- Staff at Cromer stated that communication regarding changes to clinical practice, initiated at the Norwich site, did not occur in a timely manner. Staff gave the example

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of an updated consent form for cataract surgery that was in use at the Norfolk and Norwich site but not at Cromer. The Cromer version was dated 2004, and did not include risks of surgery.

- Following the investigation and subsequent root cause analysis of the ophthalmology never event at Cromer in November 2014 all patients for eye surgery now have the eye mark as a clear indication of the correct side to reduce the risk of a reoccurrence.
- Junior doctors were not always confident how to report incidents. Some doctors reported that they would rely on the ward manager or matron to report incidents.
- Mortality and morbidity meetings (Mortality Committee) were routinely held across the division every month. This meant that medical staff reviewed recent patient deaths to identify any concerns and identify potential learnings to improve patient safety. Minutes showed that appropriate cases were discussed, that clinical and other factors considered and any lessons learnt clearly identified.

Duty of Candour

- Most nursing and medical staff were aware of their responsibilities under the duty of candour regulations. Staff stated that they knew that they had to be honest and open about any untoward incidents that occurred.
- Following the ophthalmology, never event at Cromer the patients and carer were seen by a consultant. The patient was re-examined and the treatment provided to the correct eye.

Patient Safety Thermometer

- Patient Safety Thermometer data showed that between July 2014 and July 2015 there were 34 pressure ulcers, 10 catheter urinary tract infections and five falls across the surgical directorate.
- The nursing quality dashboard data was visible in each area. Safety crosses were on notice boards throughout the surgery wards and displayed results for patient falls and pressure ulcers (PU). This was updated monthly by ward managers.
- Most safety cross diagrams showed positive outcomes for patients. Where there were issues, action plans were in place to address these.
- The National Institute for Health and Care Excellence (NICE, 2010) recommends that all patients should be assessed for risk of developing blood clots on a regular basis, and on admission to hospital. The trust regularly

audits the completion of the assessment for venous thromboembolism (VTE). They undertake this on a quarterly basis. In July 2015 there was a 98% completion rate in surgery and in October 2015 the completion rate was 96%.

Cleanliness, infection control and hygiene

- The surgery division reported no MRSA bacteraemia in the preceding year 2014- 2015. They reported seven cases of MSSA bacteraemia in the year April 2014 to March 2015. The first quarter of this year 2015-2016 also showed no cases of MRSA and only one MSSA bacteraemia within the surgical division.
- In the first quarter of 2015 to 2016, there had been seven cases of **Clostridium difficile** (C Diff) within the surgical division.
- Ward areas were visibly clean at both Norfolk and Norwich hospital and Cromer hospital. Environmental audits showed that ward areas consistently scored in excess of 95% for cleanliness.
- There were adequate hand washing facilities available and alcohol gel dispensers were available throughout wards and corridors. There was inconsistent use of handwashing and decontamination processes; on Dilham ward staff were observed to wash their hands appropriately whilst on Gately ward three staff did not wash their hands between patient care.
- The trust audits handwashing compliance across the surgical units and the latest figures for August 2015 showed that all surgical areas apart from Dilham ward (97%) and emergency assessment unit (surgical) (93%) met the trust's target of 100%.
- There was personal protective equipment available. We observed that isolation facilities on Dilham ward were appropriately used and a plan of care that was agreed by the microbiologist in place. We saw doctors and paramedical staff observing infection control processes when undertaking the ward rounds.
- Cleaning staff were contracted through an external provider at both sites.
- Within the endoscopy unit, endoscopes were properly cleaned and decontaminated in line with national guidance. However there was no robust process or oversight of the decontamination processing of flexible endoscopes within the operating theatres.
- There was a paper system in place to record cleaning, decontamination and use of each scope against patient details to ensure traceability. However

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these records were not completed accurately or appropriately. Not all individual endoscopes were numbered and patient details were not always completed which meant that traceability was not robust. Three books were in use, which meant that one endoscope could be recorded in one book at the decontamination stage prior to use and then another for when processed after the procedure. This meant that there was no easy way to ensure that any endoscope had been appropriately cleaned and decontaminated both before and after use.

- The processing machines in use had not been serviced in the appropriate time frame. We found that there were no suitable drying cabinets. There was no oversight by senior staff to the number of staff processing scopes or that they had the appropriate competency. Staff were observed to wear gloves but no aprons.
- One member of staff stated that in an emergency, when difficult intubation occurred, the fibre-optic laryngoscope would at times be taken directly out of the cupboard without decontamination.
- Staff stated that there were plans in place for an endoscope vacuum packing system to be implemented that would prolong the aseptic storage. This would also provide protective transportation of endoscopes but this had not yet been introduced.
- We raised these issues on site and local decontamination in main theatres was discontinued immediately and all items were transferred for processing to the endoscopy day unit (EDU). Since the inspection the one drying cabinet that had not been in use in the EDU has been put into service and the vacuum packed system has been introduced. Training has started with staff and the inventory of scopes from main theatres has started to be included on the EDU tracking and traceability system.
- There were different systems in place at both Cromer and Norfolk and Norwich sites to indicate when equipment was clean and ready for use. Different coloured stickers were in use to indicate items that were clean. This ensured that only equipment that had been cleaned was used for patient care.
- The design of the environment at Cromer was themed around the seaside. There was a pleasant mobile of seabirds within the main atrium however; staff were unsure if this was cleaned regularly. Curtains were in use

to separate patient bays in the ward area and staff stated that these were changed weekly but there was no audit record to ensure this was undertaken as scheduled.

- Flexible endoscopes were decontaminated at the Cromer site with a three-part Tristel system, which included a pre-clean, sporicidal treatment and rinse procedure in line with national guidance. Audit paperwork was completed to allow traceability. Sterile disposable sheaths were in use for each patient to a further reduce the risk of infection.

Environment and equipment

- Resuscitation equipment was available in all areas and were recorded as checked daily in line with trust policy. All staff were able to tell us the location of the emergency equipment.
- Equipment in ward areas such as hoists and infusion pumps were all tested and serviced in line with manufacturers guidance and electrical testing requirements.
- Specialist equipment such as bariatric equipment was stored in the equipment library and requested as needed. Staff reported that most equipment was available as needed although air mattresses were sometimes in short supply due to the needs of patients throughout the hospital.
- Manual handling equipment was used to move patients that required assistance. Staff used equipment as required in the day surgery area and in the theatre environment.
- Equipment checked during inspection, had been tested for safety through the portable appliance testing system used by the hospital.
- Lasers surgery took place in the operating theatre at the Cromer site. The operating theatre was lead lined and external illuminated signs were in place to indicate when x-ray or lasers were in use to prevent staff walking into the controlled area. There was a nominated senior member of staff as laser protection supervisor with the laser protection advisor cover at the Norwich site. The last audit had taken place in September 2014; staff stated the LPA visited each October therefore the yearly audit was overdue.
- Systems were in place to ensure use of the laser was monitored and controlled effectively. Laser keys were secured in the controlled drug cupboard when not in use, and only nominated trained staff had the

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responsibility of accessing the keys. The laser policy was in date, November 2015, there were adequate numbers of protective laser glasses, window blinds were in situ and the Laser service report was completed on 5th October 2015.

- Records of laser-trained staff were in place but not robustly updated. On review two operator statements had not been updated, one from November 2012 and one from November 2009.

Medicines

- Medicines were generally kept securely behind closed doors on all wards and departments as per hospital policy. We reviewed the theatre department and found this was also the case here. One ward (Dilham ward) had two intravenous medications prepared for administration but that these were left within the secure room.
- Medicines, including those requiring cool storage, were stored appropriately. On one ward (surgical assessment unit) we noted that temperatures in this room had been as high as 29 degrees. This could affect the efficacy of the medications stored within this area.
- There was a pharmacist allocated as designated lead to three wards and this allowed the staff on the wards to become familiar with them and increased safety within the ward areas. These designated pharmacists visited the wards on a daily basis Monday to Friday to ensure that new medications and discharge medications were available.
- We reviewed the prescription and medicine administration records for 20 patients on the 10 wards we inspected. There were appropriate arrangements in place for recording the administration of medicines. These records were clear and fully completed. The records showed people were getting their medicines when they needed them, any reasons for not giving people their medicines were recorded. This meant people were receiving their medicines as prescribed.
- Cytotoxic medications were used for treatments at the Cromer site. There were appropriately coloured, purple, sharps bins and clinical waste bags to ensure easy identification and a cytotoxic spill kit was available and within date (expires March 2017).

Records

- Security of patients' medical records was not robust. Patients' medical records were kept in unsecured

trolleys in the corridors of most wards. They were easily accessible for staff but would also be available to members of the public as they were not locked or secured. A risk assessment had been undertaken in relation to this.

- Nursing notes were kept at the bottom of individual patients' beds. This meant that they were accessible to care staff.
- We checked 18 records and found that they were in general well completed. Nursing staff completed risk assessments appropriately for patients. However in two records on Earsham ward, visual infusion phlebitis (VIP) scores had not always been assessed and there were omissions of date of cannula insertion making cannula management more challenging. Also on Earsham ward two patients had not had their observations undertaken as frequently as requested.

Safeguarding

- There were clear processes and procedures in place for safeguarding people at the trust. Nursing staff and junior medical staff spoken to were able to describe what they would do and how to recognise a vulnerable person.
- A safeguarding lead was available for advice and support. Staff on Denton ward were able to give examples of when they had referred patients to the safeguarding lead and the support they received.
- Staff had eLearning in safeguarding, dementia and dignity training. The majority of nursing and medical staff were trained to level 2 safeguarding with over 85% up to date with training.
- The trust had recently undertaken a "safeguarding week to raise awareness". Awareness of safeguarding was displayed by all grades of staff including physiotherapists and a housekeeper we spoke with.

Mandatory training

- Delivery of mandatory training was by a variety of methods including ELearning and face-to-face sessions. Training included fire safety, basic life support, health and safety, infection control and information governance.
- The trust set an internal target of 85% completion in November 2015 for all staff groups for mandatory training. For surgical staff the overall training completion

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rate was 73%. Training completion rates for Ethnicity and Diversity was 80%, Medicines Management was 75%, infection control (nursing) was 78% and infection control (medical staff) was 51%.

- Some staff on Denton ward stated that they experience difficulty in being released to undertake face to face training. However this was not the same for all wards as Dilham ward duty roster highlighted when staff were due for training and a replacement sought.

Assessing and responding to patient risk

- The national early warning system (NEWS) was in place across the surgical areas to identify any change in patient condition and ensure timely appropriate escalation for deteriorating patients. We reviewed 18 nursing and medical notes and in 10 cases the NEWS score was completed appropriately. On Denton ward staff stated that when they were short of staff they did not always have time to complete the patients nursing records appropriately. We reviewed records from this area and found that there were gaps in recording.
- Most wards had between 37 and 39 patient beds, in bays of six, and were arranged around a central facilities hub containing kitchen, sluice, clean prep area etc. This meant that a separate nursing desk was situated on either side of the ward so that patients could be seen from each of these stations by staff writing in patients notes.
- There was a trauma consultant nominated as lead of the day that held a trauma meeting every morning at 8am to assess patients and overnight admissions.
- In the theatre department and day surgery unit the theatre team hold a safety huddle at the start of each list to review workload, staffing and equipment. This ensured that the risks to patients were reduced. However, this huddle was not formally recorded.
- The five steps to safer surgery and world health organisation (WHO) checklist was utilised and audited in all theatres. All aspects were observed including team briefing, sign in, time out, sign out and debrief. The checklists were completed electronically on the scheduling system. Current compliance rates were between 96 and 98%.
- These audits monitored completion in a quantity respect but there were no local audits or measurement of the quality of these checks. This was also the case at the Cromer site. The WHO check was observed at Cromer and information completed at the computer by

a member of staff rather than focus being centred on the patient. There was a risk of complacency amongst the team as, when questioned, no formal assurance that checks were undertaken appropriately could be given apart from the team being small and all staff knew each other. Having brought this to their attention the service was planning to audit the quality of the checking procedure in the future.

- Staff in theatre in Cromer completed instrumentation checks against tray checklists however; the check was not recorded correctly on the checklist. This meant that should there be a query regarding a missing instrument there was no way of tracking at what point this occurred.
- Following an incident in ophthalmology, the department had commenced putting a red wrist band on the patient's arm indicating the side to be operated on however this was not consistent with the process in Cromer where the patient's forehead was marked.
- There were a number of patients who were not on the appropriate ward during the time of the inspection. Concerns had been raised by staff, and documented, about the care of patients on wards which were not designated to cover the speciality treating the patient. However, nurses and medical staff assured us that so-called outliers were reviewed daily by their admitting team. However nurses told us that they had to remind doctors where these patients were.
- Staff at Cromer identified that patient transfer due to deterioration was one of the biggest risks. If patients required overnight admission, they were transferred to the Norfolk and Norwich site. The transfer was by ambulance and at times delays occurred.

Nursing staffing

- There was ongoing nurse recruitment across the surgical areas. Where nurse vacancies existed agency and bank staff were utilised to bridge gaps. Between January and March 2015 the percentage of agency and bank usage ranged across the wards from 7% to 22%. Docking and Gissing ward were among the lower users of agency and bank at around 8% whereas Gateley and Earsham used between 19 and 22% agency and bank. Staff on both these wards raised issues with care.
- One surgical matron stated that there were 33 vacancies across surgery. This was in line with the information

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provided by the trust prior to our inspection. The trust had invested in training of the healthcare assistant workforce through the NVQ route to support registered nursing staff.

- The service uses the safer nursing tool to determine the numbers of registered nurses on duty. This is flexed in line with clinical judgement and indicators such as numbers of red flags and key quality indicators. However in general the surgical staffing was five registered nurses and three healthcare assistants during the day with numbers reducing to three registered nurses and two care assistants during the night.
- We spoke to a number of staff who stated that they regularly lost the third registered person or a healthcare assistant to another ward. This meant that there were four care staff available for up to 39 patients on most wards. We asked if a risk assessment had been undertaken to assess the risk of harm and were informed that this had not been completed. The lack of staff posed a challenge for the staff on Gateley ward as it often required five carers to turn patients with spinal problems. In the event that there were not five carers on the ward they would borrow staff for this purpose from another ward. We reviewed the records on Gateley ward and found that between 1 and 10 November there had been six shifts where the ward were one registered nurse below their safer staffing level. In October 2015 the total number of lost registered nursing hours during the day was 276 with only 12 hours having been replaced. A healthcare assistant covered most of these hours. During the night the number of lost hours was 204 of which 60 hours were filled by healthcare assistants.
- We heard and saw a similar picture across all surgical wards. Registered nurses were most frequently replaced with healthcare assistant hours. Staff on Denton ward stated that this impacted on patients receiving pain medication. However, the impact was also seen on the provision of care rounds and providing one to one care to patients.
- Gateley ward had been identified as not suitable for supporting nursing students and the decision had been taken to remove students from this ward however they had been reinstated from September 2015.

- There were 11 registered nursing staff at Cromer. Staff were flexible and worked both on the wards and in theatre. Staff turnover throughout the hospitals was slow. One nurse stated that they had waited for four years before the opportunity of a post became available.

Surgical staffing

- The consultant cover varied between ward areas depending on bed base. The use of locum cover was relatively low however locums were used in general surgery, trauma and orthopaedics and vascular specialties.
- There were issues with anaesthetic cover due to staffing numbers. The junior on call had changed and consultants undertook a one in seven rota to cover. To help address this staffing situation the surgery division were proactive in forward planning. The trust had recently started training four Physician's Assistants (Anaesthesia) (PAA). The PAA is a skilled practitioner that will work alongside other members of the anaesthetic team under the supervision of an anaesthetist. If this is successful they hope to continue this training and role into the future.
- The senior surgical team had identified that out-of-hours staffing were a concern and that recruitment to middle grade positions was difficult. This was identified on the trust risk register and priority was focused on recruitment alongside support for junior staff. Additional support was provided by nurse practitioners who were taking second on call on the wards.
- Weekend ward cover was provided by junior staff (First year 1 /2) and a senior house officer (SHO) with cover available from a consultant on call. Weekend ward rounds occurred and twilight cover is available from an FY1/2 doctor.
- Some junior medical staff felt that there was a strong consultant presence at weekends. Staff felt that handover was structured and well organised and junior doctors felt well supported by the consultants.

Major incident awareness and training

- There had been major incident scenarios undertaken within the surgery division and the wards had been alerted to the plans and were in the process of receiving feedback.

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- Desktop exercise scenario for major incidents were discussed at weekly senior sister and matron meetings to ensure communication across the ward areas.

Are surgery services effective?

Good



We rated surgery services as good for effective because:

- Trust policies and procedures were evidence based and adhered to national guidelines, which were available for staff to access on the intranet.
- Permanent nursing and medical staff had access to documentation and care records for patients. There were computers throughout the individual ward areas for staff to access patient information.
- Induction and competency assessments were in place for new, temporary and agency staff across all areas. There was an attempt to book regular agency staff who would be familiar with the trust.
- Multidisciplinary attendance on ward rounds and ward meetings was generally good. Three wards had access to a dedicated pharmacy lead and staff were able to access specialist support from a pain management team and a safeguarding lead.
- Good assessment of patients' nutritional needs.
- The outreach team and physiotherapy service were available seven days a week. An on call pharmacist and consultant were available at weekends.

However,

- Pain relief services were only available from Monday to Friday and patients reported varying responses to pain relief requests.
- Appraisal rates were lower than trust and national levels.
- Outcomes of audits were mixed with the trust performing well in some areas but not consistently. Outcomes were not always shared with ward managers.
- Locum and agency staff did not have access to the computer system and could not request or review information as a result.
- Staff had limited understanding to the Mental Capacity Act and could not describe the steps that they should be taking when they believe a patient may lack capacity.

We reviewed several records relating to patients who lacked capacity and found that not all of the necessary assessments, actions and documents had been completed.

Evidence-based care and treatment

- Practice guidelines were available to staff on the trust intranet to ensure practice remained in line with national guidance. Trust policies and procedures were evidence based and adhered to national guidelines.
- The national early warning system (NEWS) was in place across the surgical areas to monitor acutely ill patients in accordance with NICE guidance CG50.
- Care was provided via care bundles which adhered to national guidance. Training on the use in these was provided with consultants providing extra support to medical and nursing staff in care of patients following plastic surgery and tracheostomy care. We reviewed notes where care bundles had been used and found that these were completed appropriately.
- Both medical and nursing staff were able to describe audits that had been undertaken and actions taken to improve services.
- Policies and procedures were available for staff to access on the intranet at the Cromer site. Staff demonstrated that finding the correct document could be timely and hard copies were available in health and safety folders however there were not always kept up to date. Two of the risk assessments relating to the control of substances hazardous to health (COSHH) were outstanding for review and the COSHH standard operating procedure was dated for review in May 2012.

Pain relief

- The hospital had a specialist pain control team consisting of four nurses and two managers who all worked clinically. Referrals to the team were via an online system and via a bleep system for urgent referrals. They visited patients in the surgical directorate and provided advice and support in the management of patients' pain. However some ward staff stated that this service was only available Monday to Friday.
- Patient reports in regards to pain relief were varied. Six patients told us that pain relief was delayed at times due to shortages of staff. One patient stated that the

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specialist pain control nurses had visited them and had provided them with some techniques to deal with periods of excessive pain whilst the medication was working.

- In trauma and orthopaedics the trust was piloting prescribing pharmacists to improve the service and reduce delays for patients.

Nutrition and hydration

- Patients gave mixed reviews of the food provided. Some stated the choice was limited and another patient stated that the food was cold and not appetising.
- The malnutrition-screening tool (MUST) is a five-step screening tool to identify adults at risk of malnutrition and compliance with the care plan is monitored via the patient dashboard. In July 2015, data for the surgical directorate demonstrated that all wards were rated green with Cley and Earsham wards being rated as outstanding.
- There were signs above patients' beds that indicated their nutritional needs. A red tray system for recognition of patients that required assistance with feeding was in operation throughout the surgical directorate. Dieticians were available to support patients with their nutritional needs and we saw evidence of their input in 10 notes we reviewed.

Patient outcomes

- The trust performed better than the England average for eight of the 10 measures in the Hip Fracture Audit in 2014. They performed worse than the England average for admission to orthopaedic care within 4 hours (43% compared to an England average of 48%) and levels of pre-operative assessment by a geriatrician (32% compared to 52% nationally).
- At Norfolk and Norwich University Hospital, the risk of readmission for elective patients was generally similar to the England average. Elective general surgery patients had a higher risk of readmission following surgery than the England average. Ophthalmology patients had a lower risk of readmission. Non-elective patients had a lower risk of readmission than the England average for all specialities.
- This service had a good performance in the National Bowel Cancer Audit in 2014, performing better than the

England average for all measures except for the proportion of patients seen by a clinical nurse specialist. The trust also had high case ascertainment rates and data completeness.

- Trust performance was mixed in the 2014 Lung Cancer Audit, with 94% of patients receiving a computed tomography (CT) scan before bronchoscopy compared to an England average of 91% and 83% of patients having their cases discussed at Multi-disciplinary Team (MDT) meetings compared to an England average of 96%, and the proportion receiving surgery.
- Of the 31 items audited in the National Emergency Laparotomy Audit 2014, Norfolk University Hospital had just over half of them available. Of the 14 items that weren't available, two were available on request (post-operative input for general and elderly medicine for emergency general surgery patients). The trust had a mixed performance in the 2015 audit, with more than 80% of patients having their risks documented preoperatively and with an arrival in theatres appropriate to the urgency of the procedure. Less than half of patients had consultant surgeons and anaesthetists present in theatres, or had reviews done preoperatively by both. Less than half had direct postoperative admissions to critical care and for patients aged over 70 years, and less than half were assessed by a MCOP specialist in 2014.
- Results from the Patient Reported Outcome Measures (PROMs) for hip replacements and varicose veins were similar to the England average. Performance for knee replacements was poor, however, with risks for both the composite and the Oxford score for knee replacement treatments flagged in the CQC May 2015 intelligent monitoring report.

Competent staff

- Induction and competency assessments were in place for new, temporary and agency staff across all areas. There was an attempt to book regular agency staff as they were familiar with the areas, paperwork and systems at the trust, which reduced the risk of compromised patient safety.
- The junior doctors stated that they received induction to the trust and felt that this supported them to be more effective in the first few weeks at the trust.
- Staff on Gateley ward stated that they had significant numbers of new and inexperienced staff and this

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combined with working with agency staff led to a depletion of experience within the nursing care base. In the first three months of 2015 this ward was using on average 22% agency staff.

- The appraisal rate for the surgical directorate at the end of March 2015 for the previous year was 73%. However 90% had completed their appraisals on Dilham ward.
- Staff who cared for patients with tracheostomies were supported and received extra training from the outreach team. There was additional training from consultants for nurses caring for patients undergoing plastic surgery.

Multidisciplinary working

- We observed three ward rounds and found that there was good multidisciplinary attendance at these. There was evidence of good liaison between groups of staff including physiotherapists, occupational therapists, community liaison nurses and pharmacists.
- During these ward rounds each member of staff was asked for their opinion and their views were respected and taken into consideration.
- Ward meetings occurred twice a week which were attended by a number of multidisciplinary staff to discuss patient discharge and ongoing treatments.
- The doctors we spoke with said that they felt that there was good collaborative working with other members of the health care team.
- Some wards had designated physiotherapy, occupational therapy and pharmacy support. This meant that these staff knew the ward and felt part of the ward team.
- The minor injuries unit and radiology at Cromer hospital were adjacent to each other. This meant staff could communicate easily and collaborative working meant a complete service for the patient.

Seven-day services

- The outreach team provide a 24 hour service seven days a week. Staff could bleep the outreach team directly for support.
- The physiotherapy service was available seven days a week.
- There was a consultant on call at weekends that reviewed all new surgical patients and any post-surgery that required assessment.
- When the pharmacy closed on a Saturday there was on call support available at the weekend.

Access to information

- Substantive nursing and medical staff had access to documentation and care records for patients to ensure continuity of care. There were computers throughout the individual ward areas to access patient information including test results, diagnostics and records systems. However we saw that one monitor was left on with the details of a patient clearly visible to anyone who was standing close by. We pointed this out to a member of staff who immediately addressed the situation.
- There was a picture archiving and communication system (PACS) in place to view all diagnostic results such as x-rays, computed tomography (CT) and magnetic resonance imaging (MRI). This meant that substantive staff had timely and efficient access to images, interpretations, and related data.
- Locum medical staff and agency nursing staff did not have access to the computer system, which could compromise patient care due to inability to request or review information.
- There had been a new computer system installed at Cromer Hospital in the last 18 months. This system linked into the system at the Norwich site which meant clinicians could access patients records from either to provide continuity of care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed four patient records and the consent forms were accurate, clear and appropriately completed in all cases. All included the intended operation clearly stated, no abbreviations and were signed and dated by both the surgeon and patient.
- We spoke with staff about assessing the mental capacity of patients and found that most staff could not describe the steps that they should be taking when they believe a patient may lack capacity. This included some senior staff that were unsure if they had ever assessed anyone as not having the capacity to consent to care and treatment.
- We reviewed training records but mental capacity training was not recorded on these figures.
- We reviewed the notes of a patient on Denton ward and found that the patient clearly lacked capacity to make decisions due to living with dementia. However, decision had been made about their care by staff and

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relatives without any mental capacity or best interest assessment having been undertaken. Senior staff on this ward were also unaware that these assessments should have been undertaken.

- Staff did not have experience of the Mental Capacity Act on either Denton ward or Gateley ward
- On Gateley ward another patient living with dementia had their consent form signed by a carer. We saw that the trusts guidelines for assessment of mental capacity and decision making was available in the notes for this patient. However, appendix 2, decision making, of trust guidelines was not completed. Yet this patient had been prescribed significant pain relief.
- The notes of a patient with a learning disability were reviewed. We saw a 'rapid risk assessment' document on which this person was scored as high risk. The document explains that should someone be scored as high risk then the following should be completed: emergency admission plan, principles of the mental capacity act are followed, arrange multidisciplinary meeting. The first two were completed but no multidisciplinary meeting had been held despite the patient being referred to physiotherapy and occupational therapy.
- There was limited evidence that information gained through the patients "this is me" documentation was followed through to their care planning. Mental capacity assessments and best interest assessments had not been undertaken on this patient.

Are surgery services caring?

Good



We rated surgery services as 'good' for caring because:

- The majority of patients and relatives said that nursing staff were caring and helpful and that staff treated patients with dignity and respect. Interactions observed between staff and patients reflected this.
- In most wards, more than 90% of patients who responded to the Friends and Family Test said that they would recommend the service.
- A chaplaincy service was available to provide emotional support to patients whilst in hospital

However,

- Patient feedback on their understanding and involvement in their care was mixed.

Compassionate care

- The trust had a 35% response rate in the Friends and Family test, similar to the England average of 36%. In most wards, more than 90% of patients responded that they would recommend this service.
- Nursing care was consistently compassionate, respectful, and maintained patient dignity. One patient described staff on Denton ward as "very respectful" and another said staff maintained patient dignity by "saying 'knock knock' at the curtain before coming in".
- We observed interaction with patients on Dilham ward which was polite and caring. Patients and staff told us that they can access a chaplaincy service if needed.
- We observed patients on Earsham ward being addressed by their name and a physiotherapist using praise in order to comfort and reassure their patient. Also on this ward catering staff attended patients who may have challenges in completing their menu choice. We saw that this was discussed with the patient in a compassionate and interactive way.
- Consideration regarding confidentiality during verbal discussions during the multidisciplinary ward rounds was noted on many wards. However on Denton ward we noted that other patients could overhear the conversations from ward rounds and that there was limited introductions of staff to patients. We spoke with 15 patients and six relatives, the majority of whom said that nursing staff were caring and helpful and that staff treated patients with dignity and respect.

Understanding and involvement of patients and those close to them

- Patient feedback on their understanding and involvement in their care was mixed. We spoke to patients who felt that they had received excellent treatment and felt that they understood the care that they had been given. However, on Edgefield ward, one patient thought that they were going home only to find out that this was reliant on the results of their blood test.

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- One patient had found the consultants medical secretary very helpful in that they kept them informed of how long they would have to wait for their operation. This patient felt that they had been fully informed of their plan of care and consulted about the plan.
- A patient on Gissing ward felt that the doctors had explained their procedure to them in words they could understand. They also said that the nursing staff tell them what they are going to do before they do it. This patient felt that they understood and were involved in their care.
- One carer of a patient with dementia that had undergone surgery at Cromer hospital stated that the “staff had been fantastic and that they were extremely impressed”.

Emotional support

- The chaplaincy service was available to support patients whilst in hospital. One patient spoke highly of this service and how they had benefitted from using the service.
- Patients were involved in decisions for their treatment and given appropriate and timely support and information. For patients undergoing joint replacement (hip and knee) there was a support session (school) every Friday where advice and support was provided.

Are surgery services responsive?

Requires improvement



We rated the responsiveness of the service as requires improvement because:

- Five of the nine surgical specialties did not meet the 90% standard of the proportion of patients waiting less than 18 weeks from referral to treatment.
- The proportion of cancelled operations which were not rebooked within 28 days has been worse than the England average since April 2013.
- Patients on several wards told us that there were delays in call bells being answered as staff were busy.
- Handling of patient complaints and information provided to staff was not consistent across all areas.

However,

- There was a good discharge service on some wards and ward to ward transfers did not frequently occur after 10pm.
- The surgical assessment unit received patients from the emergency department and GPs 24 hours a day seven days per week.
- The service monitored the use of its theatres to ensure that they are responsive to the needs of patients. The service had opened the day case theatre on Saturdays to elective cases to meet the needs of local people.
- Matrons undertook a daily and weekly review of patients that were coming into hospital to ensure that a bed was available to meet their needs.
- Cromer hospital provided numerous one stop clinics for cataract surgery and urology. This meant that patient could be seen and treated in one appointment to improve patient experience and reduce delays.

Service planning and delivery to meet the needs of local people

- The surgical service works with the tertiary centre when undertaking complex cases. Advice is sought and some patients are transferred into the centres care. However we noted from governance meeting minutes that this was not always easy to access.
- The service monitors the use of its theatres to ensure that they are responsive to the needs of patients. The average theatre utilisation was 68%. The service had opened the day case theatre on Saturdays to elective cases to meet the needs of local people. Staff stated that theatre utilisation at Cromer was around 80%.
- Senior staff stated that services had reduced at Cromer due to the anaesthetic division raising concerns regarding no overnight care facilities and that the additional capacity did not warrant the risk in using theatres for general anaesthesia.
- Cromer hospital provided numerous one stop clinics for cataract surgery and urology. Five urology consultants attend the Cromer hospital every fortnight to support the two week wait. This meant that patient could be seen and treated in one appointment to improve patient experience and reduce delays.
- The matrons undertake a daily and weekly review of patients who are to come into hospital to ensure that a bed is available to meet their needs.
- An additional Vanguard theatre was in the process of being installed during the inspection. This unit, situated

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at the front of the hospital, will have a ward and theatre and will be utilised to reduce the number of day cases waiting surgery. Senior staff estimated that the unit would be operational by December 2015.

Access and flow

- Throughout 2014, the proportion of patients waiting less than 18 weeks from referral to treatment was below the 90% standard. Performance then fell from 88% in July 2014 to 70% in May 2015. Five of the nine specialties did not meet the 90% standard: General Surgery, Ear, Nose and Throat, Trauma and Orthopaedics, Oral Surgery and Plastic Surgery. Data from November 2015 showed that performance was at 69% which meant that this was a deteriorating picture.
- In this trust, the proportion of cancelled operations which were not rebooked within 28 days has been worse than the England average since April 2013. Data from April to June 2015 showed that 42 procedures (19%) of all cancelled operations were not re-scheduled within 28 days. Data from July 2015 to September 2015, showed a reduction in this number to 26 procedures however latest data (November 2015) indicated a slight increase to 31 which meant that improvements were not yet sustainable enough to show a consistent improvement.
- The proportion of elective operations that were cancelled was similar to the England average, at around 1% in April to June 2015.
- There was a dedicated bed manager allocated to surgery. On a daily basis they checked the bed state and liaised with the site team. Planned numbers of admissions were reviewed considering the balance of elective and emergency admissions. If cancellations were likely due to capacity the situation would be escalated to the director of surgery and operations manager to liaise with the clinicians involved.
- Nurse led discharge was in place within trauma and orthopaedics. On Denton ward we noted a good discharge routine. This began at the ward round at 7.30am which was attended by all staff. The ward round identified patients who were to be discharged that day. A specialist nurse practitioner wrote the discharge letter and ensured that any medications were available so that patients could anticipate a pre-lunch discharge.

- Ward transfers did not frequently occur after 10pm. Data showed that in July 2015 in most wards the number of transfers between 10pm and 6am averaged at five. However on Edgefield ward the number of transfers was 17 which was the highest for the surgical directorate.
- The surgical assessment unit receives patients from the emergency department and GPs 24 hours a day seven days per week. It has 24 beds and six side rooms. This ensures that patients are treated and discharged in a timely manner and admission was avoided where possible. Some patients who need surgery are discharged home and return at a later date for their surgery. The service had access to investigations from 8am to 9pm when an on call service becomes available. The unit has a dedicated emergency theatre for urgent operations. However when this unit was full patients would be admitted to the day surgical unit for overnight observation. This occurred 13 times in October 2015.

Meeting people's individual needs

- Patients spoken to on Gateley, Gissing and Denton ward told us that there were delays in staff answering call bells as they were busy. This was worse at night time when patients noted that there was a shortage of staff.
- We noted two patients who had a learning disability on two wards, Denton and Dilham. Both patients had extra care provided by their regular carers in addition to hospital staff. This ensured that there was continuity of care and provided reassurance for the patient.
- We noted that there were leaflets available on a number of different procedures and conditions. These were available in other languages.
- Staff were aware of the availability of translation services.
- On Earsham ward we noted that there was a different sounding call bell to alert staff to the needs of patients with complex needs.
- We noted that all toilets can accommodate a wheelchair on Earsham ward. The staff on this ward prioritised the end beds for patients in wheelchairs as there was more space for their chair.

Learning from complaints and concerns

- In July 2015 the surgical directorate had 15 complaints and 12 concerns raised about the care provided.
- Handling of patient complaints and information provided to staff was not consistent across all areas.

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Most staff stated that verbal complaints were dealt with on ward and not documented. However other ward staff said that they reported every complaint even when made verbally.

- Written complaints were managed centrally but ward manager and matron stated that they were involved in the review of these complaints.
- Complaints were shared with staff at handovers and staff on Earsham ward were able to share complaints and resulting changes to care as a result of these complaints being investigated.

Are surgery services well-led?

Requires improvement



We rated surgery services as 'requires improvement' for well-led because:

- There had been a change in the leadership team and whilst some staff felt that the culture had started to improve others reflected that staff morale was still low within the surgery division with staffing and clinical pressure a contributing factor.
- Pressure on bed capacity meant that the ward staff felt pressurised to take patients who were not suitable for their ward areas. In particular concerns had been raised by staff regarding the use of the day procedure unit as an escalation area and staff felt unsupported by the senior team when risks were highlighted.
- There was no standard operating procedure in place for the use of the day procedure unit as an escalation area despite staff raising concerns.
- There was no governance, quality or risk management process in place for the process of endoscopes within main theatres to ensure patient safety
- There was a lack of managerial support for senior staff at Cromer and staff raised concerns about the timeliness of communication from the Norwich site.
- Actions from monthly directorate meetings at Cromer were not robust in terms of stipulating delivery times of actions identified or the nominated person who was to be accountable for ensuring tasks were undertaken.

However,

- Most staff were aware of the vision and values of the trust.

- There were monthly surgical governance meetings, which were attended by the matron and the ward managers. There was evidence that the ward team were held to account during the meetings for the quality indicators used at the trust.
- Junior staff felt supported by their ward managers and most ward staff felt that they had a good team.
- Staff at Cromer hospital stated that culture was good, with many staff members who had been in post for a significant amount of time, a low turnover, a full complement of staff, minimal staff sickness and good local leadership.

Vision and strategy for this service

- Most staff were aware of the vision of the trust to provide every patient with the care we want for those we love the most. Staff were aware of the values of the trust which were PRIDE (people focused, respect, integrity, dedication and excellence). Senior staff felt that this was embedded throughout the directorate.
- The majority of consultant staff could describe the vision of the trust but could not describe the values.

Governance, risk management and quality measurement

- Surgical governance meetings occurred monthly and these were attended by the matron and the ward managers. During this meeting, there was evidence from the minutes that the ward team were held to account for the quality indicators used at the trust. The main concerns raised were about staffing levels on the ward areas.
- However the quality of the governance meetings was not consistent or robust and did not provide assurance of oversight of risk and a joint approach across both the Cromer and Norwich sites. The effectiveness and timeliness of communication was identified as a concern, particularly in relation to lessons learnt and changes to clinical practice. The incident of two never events highlighted a breakdown in the effectiveness of risk management. There were no local audits or measurement of the quality of the World Health Organisation (WHO) checklists at either site.
- The robustness and training of staff undertaking root cause analysis was limited as was the follow up of changes implemented. Following the ophthalmology never event an audit and action plan were produced to reduce the risk of reoccurrence. However the follow up

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of these was not robust and there were outstanding actions at the time of inspection that had deadlines of February and July 2015. The re-audit of the surgical procedure for eye injection had been planned for October 2015 but this had not taken place.

- There was no governance, quality or risk management process in place for the process of endoscopes within main theatres to ensure patient safety. Despite reacting immediately to issues raised during inspection, there was an obvious disconnect between process for decontamination in separate areas of the trust and standards were not assured in all locations.
- There were concerns identified by staff regarding the use of the day procedure unit as a first escalation area and the impact on the quality of patient care. The area consisted of bays that restricted observation of patients remaining overnight which had an impact on patient safety as often patients admitted had a high acuity. The unit was not staffed overnight and often the night staff allocated consisted of one substantive nurse and one agency. There was no standard operating procedure in place; however nursing staff had requested this. Staff had implemented the process of day surgery patient being admitted in the pre- assessment area rather than bed spaces to keep patient flow and reduce service disruption to the minimum. Issues had been raised with the director for surgery however staff stated that there was little support from the senior team.
- Monthly directorate meetings were held at the Cromer site with good attendance and agenda covered all aspects such as safety, complaints and risks, but actions were not robust. Minutes from the meetings did not demonstrate delivery times of actions identified or the nominated person who was to be accountable for ensuring tasks were undertaken.
- Staff stated that the risk register for Cromer was included as part of the trust overall risk register. However, the management and oversight of risks, was not robust and several risk assessments needed to be updated.
- The directorate had a governance system by which information is shared. Staff noticeboards displayed key pieces of information. The information boards also displayed action plans to ensure that all staff were aware of changes to practices.
- Junior staff were aware that these governance meetings were held and knew that the information boards would be updated as a result.

Leadership of service

- Junior staff felt supported by their ward managers. Most ward staff felt that they had a good team and could raise issues of concern. Ward staff felt that the matron, who visited the wards daily, was approachable and accessible.
- Some staff reported pressure from the site operations team to take patients onto the ward when nursing staff felt that they were not appropriate for their particular ward.
- Most staff were aware of the director of nursing and knew how to contact them. Staff were also aware that they had a new chief executive and found that communications with the senior team were improving. However, several staff stated that whilst issues were highlighted and discussed action was not always taken in a timely manner.
- The surgical specialty were positive and proactive with new initiatives such as nurse led discharge, and pharmacist prescribing within trauma and orthopaedics and enhanced recovery.
- There was a lack of managerial support for senior staff at Cromer due to the focus on leadership at the Norwich site. The senior manager was new in post, having been recruited in May 2015. They reported into the divisional director for surgery, cancer and women's and children's service, but had only had three meetings at Cromer in the six months since taking up post. The chief executive had visited the Cromer site and was due to commence bimonthly visits from 14 December 2015.
- There was a disconnect between Cromer and the main Norwich site. There was evidence that staff felt disengaged with. The director of nursing was not visible at the Cromer site and staff stated that there was a delay in receiving updated processes and protocols.
- Local leadership at Cromer was good. There were monthly senior nurse meetings and weekly team brief meetings that were documented and demonstrated good communication with staff at all levels.
- Some areas felt that they did not see the senior management team as much as others did. There was a staffing review within the day surgery unit which staff were anxious about. Senior managers were working with staff including sending them to other units to see staffing levels and involving them in these discussions.

Culture within the service

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- Whilst most staff felt that ward teams were supportive and enjoyed working within them they felt that morale was generally low amongst staff in the surgical directorate. Staff on Dilham ward had recently won an award and were extremely proud of this fact.
- Staff had a number of complaints including that they felt that the senior team used audit as a “big stick to beat” them, opportunities for training was reduced and when taken they only get 50% of the time back.
- The trust had implemented a staff survey to capture the mood of the staff as the previous NHS staff survey results had been poor. A decision had been taken to issue this as a paper letter as email traffic is easy to ignore. However this had not been communicated with staff in the surgical directorate who felt that the paper letter was a waste of money.
- Whilst many staff said that culture had improved since the new leadership team had been in post. Seven staff reported that there was a disconnect between managers and ward staff. When we explored this further it became obvious that this was between the operational managers and the clinical team. This appeared to relate to pressures for beds.
- Staff felt most disheartened when speaking about the lack of staff and the pressures this caused on them. Most were able to relate how this had also impacted upon patient care and how this made them feel. Some staff reported that this pressure meant that team meetings were not held and that they felt that they were constantly requesting more staff.
- Doctors felt supported by their colleagues and consultants. They spoke of good joint working across teams.
- We were aware that the trust had had issues with a bullying culture and asked staff about this. Most staff felt that the culture was much better. We heard only one negative experience in the recent past in respect of

some feeling bullied. Staff at Cromer hospital stated that culture was good and benefited from a small, close-knit team. Many staff had been in post for a significant amount of time, turnover was low, there was a full complement of staff and staff sickness was minimal.

Public and staff engagement

- The trust had a number of volunteers who worked within the hospital. Part of their role was to assist patients to complete the friends and family test on discharge.
- Locally ward managers had involved their staff in the direction of travel for their ward or area. Staff were able to share experiences of where this had happened.
- There was a hip and knee school which ran on a Friday afternoon jointly by a practitioner and physiotherapist that provided support and advice to patients having joint replacements.
- Some staff were aware of the chief executives meetings at which he communicated to staff but few we spoke with had attended.
- Staff at Cromer stated that communication from the Norwich site at times was slow and could be improved.

Innovation, improvement and sustainability

- In order to improve services the trust had begun to erect a Vanguard theatre unit which would increase the capacity to undertake more operations.
- We found that the site at Cromer was underused and had spare capacity. This was acknowledged by the management teams. However, it was not clear if senior management included consideration of the Cromer site in sustainability plans.
- We heard that the trust had held succession planning days for staff nurses who aspired to be ward sisters. This ensures that people were developed and succession planning was more successful.

Critical care

Safe	Requires improvement	
Effective	Good	
Caring	Good	
Responsive	Good	
Well-led	Good	
Overall	Good	

Information about the service

The critical care complex (CCC) at Norfolk and Norwich University Hospital is a well-equipped, recently refurbished unit formed of a high dependency unit (HDU) for level two patients and an intensive care unit (ICU) for level three patients. There are ten beds on each unit, including four private side rooms that can be used for isolation. The combined unit can be staffed and configured flexibly to meet the needs of patients, including the use of bed spaces in the ICU for level two patients if needed.

Two consultant intensivists work in the CCC during the hours of 7.30am – 8pm Monday to Friday, with a dedicated consultant overnight. A band eight matron, with support from four band seven nurses, led the nursing provision in the unit.

Patients were admitted to the CCC from the emergency department, the surgical unit and other hospital departments. Two bed spaces in a separate recovery unit were equipped to care for level two and level three patients if the CCC was full to capacity. The beds used were part of an escalation plan that enabled staff to provide continuous care during episodes of exceptional demand.

The hospital had the fewest general critical care beds per major operation in their peer group and performs more major operations per hospital bed than any other trust nationally.

We spoke with 15 nurses, six consultants and five trainee doctors, the clinical lead, the clinical director and the operational manager. We also spoke with six relatives and

four other multidisciplinary medical professionals including a physiotherapist and a pharmacist. We looked at three incident reports, 13 patient records and over 50 other items of evidence to come to our rating. This evidence included incident reports, complaints, risk assessments, local and national audits.

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Summary of findings

We rated the Critical Care Complex (CCC) at Norfolk and Norwich University Hospital as good overall. The safety of critical care at Norfolk and Norwich University Hospital required improvement. The effective, caring, responsive and well-led domains were good.

This rating reflects the considerable levels of short staffing in the medical team at trainee level out of hours. There was also a lack of coherent and responsive approaches from the trust's leadership team to resolving short staffing in line with the core standards of the Intensive Care Society.

The impact of short staffing included the loss of minimum consultant to patient ratios, an inconsistent approach to ward rounds, medical handovers, and additional pressure on nurses and junior doctors overnight. The standard of the ward rounds and handovers we observed was very good but there was sometimes a reduction in the continuity of care because the specialist registrar was often called away to other areas. However, we found that a new operational manager, the clinical lead and the critical care matron worked cohesively and systematically to establish improved governance and management oversight. This built a more salient relationship with the trust's executive board. We found a positive change was beginning to take place because of this and critical care staff told us that they felt much more supported and stable. A more robust, evidence-based response from the trust executive team to risk assessments produced by clinical staff, was cited as an urgent requirement by senior clinicians we spoke with.

The ethos in the unit was one of improving clinical practice and continuing to stabilise a staffing team that had been impacted by long-term staff shortages, significant capacity issues and the departure of two previous matrons in a short space of time. Staff were encouraged and supported to continually challenge existing practice. Senior nurses and consultants in the unit demonstrated how they applied such challenges to national standards and patient outcomes, which resulted in a programme of audits and care strategies focused on improving patient care.

Clinical practice was benchmarked against the National Institute for Health and Care Excellence (NICE), the Royal College of Physicians, the Faculty for Intensive Care Medicine, the Nursing and Midwifery Council (NMC) and the Department of Health (DH). Such guidance was embedded into the working culture in the unit and staff monitored the outcomes of this practice through an improved clinical governance and risk management structure.

Staff contributed to the Intensive Care National Audit and Research Centre (ICNARC), the outcomes of which they used alongside local audits to contribute to the planning of staff study days. Learning from incidents was used to deliver practical simulation training for the multidisciplinary team. The CCC team had access to multidisciplinary specialists who routinely contributed to decision-making and ward rounds in the best interests of patients. Some of this access was limited in scope and nature, including a lack of pharmacy and dietetics cover. An established critical care outreach team (CCOT) supported deteriorating patients across the hospital, conducted safety audits and provided a substantial education service to nurses and doctors across wards and departments.

The CCC was clean, well maintained and staff demonstrated good infection control practices. Equipment was serviced regularly and staff were trained in its use with regular updates. The storage of medicines in the intensive care unit, (ICU), was not free from risk or appropriately risk assessed due to limited security-controlled access to certain drugs. A risk assessment was submitted to us after our inspection with a plan to rectify this.

A robust incident reporting system was in place that staff used confidently to investigate incidents. There was evidence that learning from incidents and investigations had taken place consistently with an effective system in place to ensure all staff were aware of updates to practice. While this was the case in the unit, support from the trust executive team had not always been forthcoming. There was a lack of evidence that risks escalated to the senior leadership team had been responded to or actioned appropriately.

A clear focus on delivering person-centred care met the needs of each individual patient. This included a record

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of improving facilities for their relatives following feedback, the use of patient diaries and the provision of iPads to relieve boredom and help staff to communicate with those who could not speak.

Are critical care services safe?

Requires improvement



We rated critical care services as requires improvement for safe because:

- The unit did not consistently meet minimum staffing guidelines for both nursing and medical staff at certain times according to Intensive Care Society (ICS) guidance
- Clinical staff had escalated this as a serious risk to the executive team and had not received an appropriate resolution. This was evidenced in part by the exclusion of medical staffing levels from the action plan that had resulted from a serious incident investigation.
- Although clinical staff were confident in the use of reporting incidents and there was evidence of innovative practice in implementing learning from investigations, a robust incident tracking and dissemination system was not in place from the senior leadership team. This issue was beginning to be addressed by a new operational manager.
- Medicines were stored and administered appropriately with the exception of medicine storage in the intensive care unit, which was compliant with trust policy but unlocked and without a robust risk assessment to address the risk of unauthorised access

However,

- There was a clear and transparent system for reporting and investigating incidents.
- Significant opportunities for the professional development of nurses and well established protocols for deteriorating patients. .
- Staff in the unit were specialists in their field and worked well together to mitigate the impact of short staffing on patient outcomes and staff morale and individual patient care was good.
- Equipment was maintained in line with manufacturers' guidance and infection prevention and control systems were established and observed in practice.

Incidents

- Between August 2014 and July 2015 there had been one serious incident (SI) and no Never Events in the Critical Care Complex (CCC). Never Events are serious, largely

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preventable patient safety incidents that should not occur if the available preventative measures are implemented. The SI investigation had followed trust protocol but had not initially been categorised by the trust's risk management team as a serious incident under the definition of the National Patient Safety Agency. Three months after the incident was reported, it was recategorised at a clinical governance meeting as an SI under the national framework for reporting and learning from serious incidents requiring investigation.

- The lack of sufficient junior doctors out of hours had been highlighted as a contributing factor by a clinician and included within the root cause analysis (RCA). A risk manager had downgraded this risk on the unit's risk register, citing a miscalculation in the risk rating. Although staff had implanted a structured and comprehensive nine-part action plan as a result, medical staffing levels were not included in the action plan and therefore did not address low overnight medical staffing levels as one of the key contributing factors. The omission of the risk attributed to a lack of clarity regarding accountability for managing and reporting clinical risks relating to staffing.
- Staff used an electronic incident reporting system to submit an incident. The system automatically sent them an acknowledgement of the report and staff were able to track the progress of the investigation using an incident tracking report maintained by senior staff. Incidents were investigated using a root cause analysis process by a senior member of the nursing or medical team allocated based on their expertise regarding the nature of the incident. The process of review used by divisional directors for root cause analyses of serious incidents was unclear. Clinicians in the CCC were unable to demonstrate how practice or policies had changed as a result of director-level oversight. Divisional directors were also unable to clearly show how they had improved practice as a result of incidents raised by staff.
- The unit was compliant with the NHS England serious incident framework in its reporting.
- Learning from incidents was communicated, at a local level, to staff in handovers, team meetings, a communication book that was continually updated and through monthly team training days.
- Senior staff were more critical regarding learning dissemination from the executive team. From our discussions with doctors, senior nurses and the clinical director for the division, a consistent process was not in place for accessing the learning from incidents or identifying who had responsibility for reviewing root cause analyses of incidents.
- The senior team had implemented new or revised working practices as a result of learning from incidents, such as a new algorithm for anaphylaxis that had been introduced to staff through dedicated training sessions. Action plans from incident investigations were in place but staff in critical care had to implement these on a local basis without a robust or coherent support structure at the senior level of the clinical division. For example, medical staff said that the dissemination of learning from incident investigations had been problematic. The clinical director explained that an 'umbrella' safety committee considered incident investigations as part of anaesthetic governance meetings. Some of the nurses and doctors told us that this structure was not clear to them.
- A team of five staff used simulation training to provide colleagues with the opportunity to reflect on incidents and to discuss changes in treatment practices, such as in the treatment of patients with anaphylaxis and a tracheostomy. The unit's critical care network had noted this practice as being delivered by a multidisciplinary team and indicative of innovative practice. Nurses were organised into 'mentor groups', who took part in simulation training together.
- Some incidents reported related to physical attacks on staff by patients with delirium. A senior nurse told us that training in the aggression that can result from delirium had not been provided and the support offered after such an incident was described as "an informal chat with the matron." There was a training course advertised to staff in the prevention and management of aggression and a governance meeting in November 2015 highlighted a plan to set up a work stream to deal with patient violence.
- Mortality and Morbidity (M&M) reviews took place monthly as part of directorate and divisional governance meetings and included a review of all deaths in the unit and a check of electronic patient records to ascertain the differences in treatment between expected and unexpected deaths. M&M meeting minutes were reviewed by the trust mortality committee, which monitored mortality trends.

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- A tracheostomy working group made up of multidisciplinary staff, reviewed tracheostomy incidents every three months and was responsible for conducting root cause analyses and preparing action plans.

Duty of Candour

- Nursing staff were able to explain their role in the duty of candour and could evidence how they would use this in practice, using help from prompts in the electronic patient records system.
- Trainee doctors stated they had not received formal training in the duty of candour but they were able to explain how they ensured this was adhered to in practice, including an immediate and open discussion with the patient and their relatives.
- Investigating staff had made appropriate efforts to contact relatives during the investigation of a serious incident that had resulted in the death of a patient.

Safety thermometer

- Between August 2014 and July 2015, there were seven pressure ulcers and no falls with harm or catheter urinary tract infections reported. Staff had completed root cause analyses of the pressure ulcers. Issues relating to equipment caused three of the pressure ulcers. To address this, the matron was exploring the use of modified types of equipment such as different endotracheal tube ties. Evidence from the minutes of governance meetings showed that additional air mattresses had been provided and turning charts were used consistently in the patient records that were reviewed.
- Patients had their level of risk for venous thromboembolism (VTE), falls and malnutrition reviewed and documented at intervals established by patient need. Staff completed a monthly audit of safety thermometer risk assessments. The latest available audit was from October 2015 and indicated that 13 of 16 patients had their VTE risk assessed and that VTE prophylaxis was offered where appropriate.

Cleanliness, infection control and hygiene

- Cleaning staff were visible during the day in the unit and all staff followed trust infection control procedures, adhering to the NHS national standards of cleanliness and the World Health Organisation's 'five moments for hand hygiene'. This included staff use of personal

protective equipment during patient care and the use of alcohol hand gel between patients, which was available at each bed space, private room and entrance to the unit.

- In September 2015, a local audit found the unit 100% compliant with trust hand hygiene policy and the infection control element of dress code and uniform policy. This standard had been achieved in every month but one in the twelve months prior to our inspection. Three link nurses formed an infection control group that monitored these standards.
- Housekeeping staff used 'I am clean' labels to indicate that an item of equipment had been cleaned and decontaminated. Housekeeping cleaning schedules and records were maintained in each area of the unit.
- Learning from previous incidents of patients with clostridium difficile (C.Diff) and glutamate dehydrogenase was displayed using infection control education posters on display in the unit.
- 84% of staff were up to date with infection control and hand hygiene training.
- Staff in the unit were compliant with the C.Diff. management and treatment guidance of Public Health England.
- There had been no cases of MRSA in the unit between April 2015 and November 2015.
- Not all of the bed spaces in the CCC complied with the DH Health Building Note 00-09, which meant that the minimum standard of space for effective infection control was not always met. The bed spaces predated this requirement and there was evidence that senior staff had included this in planning for future unit expansion.

Environment and equipment

- Resuscitation and emergency airway management equipment had been recorded as checked daily. This ensured that items were maintained and all items were in date for the month prior to our visit.
- Each bed space had a tracheostomy safety box that contained essential equipment and a copy of the policy for the safe transfer of patients with a tracheostomy tube.
- Staff maintained a log each time a transfer trolley was used. This log included a record of the length of the transfer, the equipment and drugs used and any

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problems encountered with the equipment. As a result of feedback from staff, a checklist for staff had been introduced to ensure that transfers took place with the correct equipment.

- We reviewed 20 separate items of equipment in storage and found them to be ready for use, with 'I am clean' stickers in place and the date of the last portable appliance test (PAT) noted.

Medicines

- The unit had systems and a standard operating procedure (SOP) in place that complied with the Medicines Act 1968 and the Misuse of Drugs Act 1971, including competent staff. All qualified nurses had undergone IV therapy training. 94% of staff had undergone medicines management training.
- Processes for medicine management, including storage and recording, were in place. Controlled drugs were kept in locked cupboards and stock was checked and recorded daily. Fluids and epidurals, including those with additives were labelled accordingly and stored separately. Medicine that belonged to individual patients in the high dependency unit (HDU) were stored in a locked cupboard at each bedside and individual cupboards had been sourced for patients on the ICU and were awaiting installation.
- Medicines that needed to be stored at low temperatures were kept in locked fridges and staff had recorded daily temperature checks in the month prior to our inspection.
- The medicine stock cupboard in the ICU was unlocked and in an open area on the unit. This complied with trust policy but there was not a risk assessment in place to address the risk of the unauthorised access to the cupboard by visitors. A risk assessment was compiled after our inspection and indicated that a swipe-card system was planned to control access to the stock while ensuring this could be rapid in an urgent situation.
- Senior nurses used handovers to communicate any changes in medicine protocols or administration, such as a reminder to flush nasogastric tubes before and after use, and only inject one drug at a time.
- Staff had updated the unit's antibiotic policy in January 2015 and this was adhered to in all of the patient records reviewed. Staff measured the defined daily dosage of antibiotics used on a quarterly basis and the pharmacist completed a monthly audit of antibiotic documentation for each admission.

- In all 13 of the patient records we reviewed, a medicines review had taken place.
- The unit's pharmacist conducted specific drug audits, including the use of antipsychotic medication.
- Consultants, with the input of the pharmacist, wrote drug policies.

Records

- Staff used an electronic patient records system to record assessments, observations, medicine and treatment. The system provided staff with direct access to trust and unit protocols and treatment algorithms. A dedicated nurse was developing the system further with the addition of new guidance for staff on injectable medicines. Nurses were advised how to use this during a handover and through a communication book.
- 79% of staff in the unit had undertaken health record keeping training and the remaining staff had this training scheduled.
- A senior lead nurse was in place with the remit of managing and developing the electronic patient records system and was supported by two dedicated link nurses. As well as working clinically, the lead nurse had 18 hours of protected time each month to maintain and develop the system. They had a well-developed technical and operational knowledge of the system in the context of critical care. They had been able to provide rapid solutions to issues with the system and had used input from staff in the department to add areas of need for effective critical care treatment, including prompts for staff to complete mental capacity assessments and to monitor pain levels at set intervals.
- Critical care outreach nurses used bright orange labels in patient notes on the wards to ensure their input and reviews were immediately identifiable.
- Allied healthcare professional staff were able to record observations, treatment and care in electronic patient notes, which enabled critical care staff to track patient needs and treatment management plans. When a patient was transferred to a ward, a printed copy of the patient's notes accompanied them.
- The electronic patient records system was used by recovery staff for CCC patients who were treated there. This meant that observations and treatment were recorded consistently.
- The critical care outreach team relied on a referral system that was not directly linked with the CCC electronic records system. This meant that when staff

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started their shift, it was not immediately clear where in the hospital patients were situated. A nurse described this system as “not fit for purpose” and told us they were concerned by the absence of a decision from CCC leadership regarding a resolution.

- Prominent bedside labels were used to identify patients with allergies and this was also recorded in each patients’ record.
- Staff had introduced a new risk assessment document for the transfer of critically ill patients using guidance established by the United States-based Institute for Healthcare Improvement.
- Care bundles were consistently used and documented for ventilation, tracheostomies and urinary catheters.
- Risk assessments and treatment management plans were used and documented in line with appropriate national guidance for moving and handling, waterlow scores and malnutrition in six of the seven patient records reviewed.

Safeguarding

- 100% of nurses in the unit were trained to level two in adult safeguarding and level one in safeguarding children. 98% of nurses were certified to level two in safeguarding children. Staff in the unit were supported by two dedicated safeguarding link nurses.
- Staff had a good understanding of the safeguarding of vulnerable adults and how this applied to the critical care environment. Staff were able to explain how they would raise a safeguarding alert and how they could contact the hospital’s safeguarding link nurse if needed.
- The electronic patient records system included a section dedicated to safeguarding, which staff could use to record concerns and contact with other specialists such as the safeguarding team or the local authority crisis team.

Mandatory training

- The mandatory training timetable was comprehensive and included two study days on haemofiltration, including the practical use of filtration machines as well as resuscitation training, spinal injury moving and handling, cardiac arrest and the British Association of Critical Care end of life care study programme.
- There was a mandatory training day each month for CCC nurses which was used to help staff remain up to date with certification in specialist areas. The study days were also used to update staff on unit developments

and on information relating to mental capacity policies. External study days were used for training in tracheostomies and palliative care and nurses also attended study days delivered by the British Association of Critical Care Nurses.

- Some staff stated that training was sometimes difficult to attend because of pressures related to short staffing. One nurse said they had missed their last scheduled infection control training because the unit was too busy and training time was not always protected. Senior staff stated that they monitored mandatory training and when an individual’s certification was about to expire, they were given allotted training time as part of their rota.
- The unit had recently employed a clinical nurse educator (CNE), after a period of vacancy. During this period a senior band seven nurse had taken the lead on nurse education and practice development. The new position was created two weeks before our inspection and it was intended that the CNE would take responsibility for maintaining nurse mandatory training compliance. The trust had downgraded the CNE role from a band seven nurse to a band six nurse which could affect the scope and responsibilities of the individual.
- During the preceding period, a senior nurse had acted as an interim CNE, taking on education responsibilities in addition to their clinical role. Nurses were very positive about the interim CNE and their ability to source ad-hoc training on demand, including recent ventilator training. One nurse said, “Their support has been invaluable and their training is absolutely superb – anything at all we need we just go to them.” Another nurse said, “Our new CNE has some great ideas, I’m very excited about them. They’re planning to build new training sessions that will be delivered by individual nurses based on their own specialty. These will be used to update our standard operating procedures and I think attending sessions like this will be much better than just getting updates by e-mail.”
- Staff were trained regularly in clinical decision-making, care and treatment using simulation exercises. In-service training days had also been used to ensure staff were competent in continuous veno-venous hemofiltration.
- The trust had implemented an electronic staff record learning system that was not fully compatible with the computers in the CCC as they had not been upgraded

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with appropriate software. This meant that staff often completed online learning programmes that were not recorded on the trust tracking system, resulting in staff being told they had to retake the training. One senior nurse said, “It causes a lot of frustration because the nurses work really hard to make sure they complete their training on time but when they get an e-mail asking why they’re out of date it wastes their time. If the IT system was more integrated, the training process would be much more streamlined.”

- Nurses who returned from a long-term absence were given six hours of protected time to update their mandatory training record.

Assessing and responding to patient risk

- A critical care outreach team (CCOT), led by a band seven nurse, was available between the hours of 8am and 8.30pm, seven days a week to see patients who were deteriorating or who had been discharged from the CCC. Outside of these hours, a band seven nurse led a hospital at night (H@N) team that would respond to requests from ward staff to assess deteriorating patients.
- A critical care outreach team (CCOT) nurse conducted an assessment of patients discharged from the CCC to a ward within one hour during the day where they had spent over four days on the unit. Where a patient was discharged overnight, they were prioritised for a review by the CCOT nurse the next morning.
- Patients were assessed hospital-wide using an Early Warning Scores (EWS) system. Where a patient was deteriorating, ward staff referred them to a CCOT nurse who was responsible for prioritising patient visits. This was achieved using a robust EWS call-out cascade that helped nurses to identify the highest risk patients. The cascade had been developed following learning from a previous root cause analysis that had taken place after a 2013 failure to rescue incident. During the time we spent with a CCOT nurse, we saw that their workload was continuous and because only one nurse managed the CCOT call-out plan, interruptions to patient treatment were frequent.
- During the night, a hospital at night team responded to patients who had triggered a review through their EWS score and were able to liaise with the on-call critical care consultant to arrange their admission if needed. One

consultant said that they considered this system to be unsafe because of the lack of sufficient on-site CCC medical staffing and CCOT nurses to respond rapidly to deteriorating patients.

- A new resuscitation and deteriorating patient group had been established and its terms of reference incorporated the guidance of the National Cardiac Audit as well as a ‘track and trigger’ system for staff to use to ensure the most appropriate specialist assessed patients.
- Paediatric referral folders kept on the resuscitation trolley were detailed but needed updating as they were out of date with current practice.
- Critical care outreach team and CCC response to deteriorating patients was planned and delivered in compliance with NICE clinical guidance 50, acutely ill patients in hospital.
- The CCOT team led an education programme designed to empower nurses and physiotherapists on the 27 hospital wards about the care of critically ill patients, including a deteriorating patient course. The CCOT lead nurse had published a ‘Using the EWS’ poster for ward staff, which was prominently displayed in clinical areas around the hospital. This provided staff with clear criteria and instructions for the interpretation of an EWS score that should lead to a CCOT referral.
- The CCOT team had developed a critical care outreach training course for healthcare assistants across the hospital that had been offered three times in the previous year. This had been poorly attended with 50% of the available spaces taken up. Staff identified trust-wide short staffing as a contributing factor and the issue was being raised through clinical governance pathways to improve future uptake. The education programme was aimed at empowering ward nurses in the care of deteriorating patients and a deteriorating patient study day for registered nurses was arranged every three months

Nursing staffing

- A band eight matron led the CCC’s nursing team, with support from four band seven nurses. Staff told us that the unit had experienced a period of uncertainty with nursing leadership, as the current matron was their third within twelve months. As part of a professional development programme, two band five nurses were

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working as more senior band six nurses. Both individuals had undergone a three-day introduction to management training programme delivered by managers across the hospital.

- The unit did not always meet nurse staffing requirements according to the Royal College of Nursing (RCN) standards. Based on the number of beds and mix of HDU and ICU patients, there needed to be 17 registered nurses per shift to meet the established safe standard. Nursing rotas and conversation with staff revealed that typically 13 – 16 nurses were on shift at the same time. The consistent short staffing of the unit meant that the nurse in charge could not always attend ward rounds.
- A draft standard operating procedure (SOP) and escalation plan for the short staffing of nurses in the unit was submitted to the operational manager and was awaiting ratification. This plan used information relating to staffing and patient acuity, recorded every six hours, to determine action to be taken if the planned number of nurses was not achieved. The SOP was written adhering to the ICS core standards for intensive care units, NICE and RCN guidance on safe nurse staffing levels.
- A supernumerary nurse coordinator was available 24-hours, seven days in the HDU but was not always available in the ICU. Although level three patients received the required 1:1 care ratio, this was sometimes at the expense of a supernumerary nurse in charge. This meant that nurse staffing level requirements of the Faculty of Intensive Care Medicine were not always met.
- There was evidence of a lack in an effective working relationship between the site practitioners and CCC nurses. Nurses stated that site practitioners would sometimes redeploy critical care nurses from the unit to a ward to cover critical short staffing. They said this was, “very, very stressful and it doesn’t seem that they [site practitioners] understand the requirements for staffing ratios in this unit.”
- Nurses said that the departure of the CCC matron in September 2015 had resulted in a period of uncertainty and that they were reassured by the appointment of a matron who had worked as a senior nurse on the unit for several years. This individual had not received any immediate management training to support them in their role but this was planned and a matron in surgery; the operational manager and the director of nursing closely supported them.
- Staff said that nurse staffing levels had recently improved and that they had benefited from the use of agency nurses. A recruitment programme was also underway to recruit nurses to cover two additional critical care beds in recovery. All agency nurses had a post-registration critical care qualification and nurses said that they had seen the same agency staff consistently and felt working experiences and patient care had been positive.
- We observed two nurse handovers and found them to be comprehensive, patient-centred and fit for purpose. Nurses were assigned to individual patients based on their level of experience and skill and there was a clear focus on patient outcomes and the involvement of their family, such as consideration of family members who had stayed at a bedside overnight.
- A senior nurse had developed a patient acuity tool to plan staffing levels, which had been successfully implemented. This meant the unit could be responsive to patient need and could increase staff: patient ratio levels within defined criteria. For example, a level three patient with complex, multiple organ failure and co-morbidities was classified as a level 3A patient and would be looked after by a nurse: patient ratio of 1.5:1. This electronic tool used a red, amber, green (RAG) traffic light system to indicate staffing levels based on nurses on shift that held post-registration critical care certification and any shortfall in staffing levels. The tool was updated every six hours and was used on ward rounds by doctors and by managers to assess capacity and patient risk. The tool was used to maintain staffing levels according to the unit’s own establishment, which did not meet RCN standards.

Medical staffing

- Nine consultants worked in the CCC, all of whom were fellows of the Faculty of Intensive Care Medicine. Day time consultant cover was provided between the hours of 7.30am and 8pm. During the day, Monday to Friday, the CCC achieved ICS Core Standards for Intensive Care Units that consultant to patient ratio did not exceed 1:15 as there was one consultant for ICU and one consultant for HDU, resulting in a ratio of 1:10. Overnight and at weekends this standard was not achieved, as the on-call consultant was responsible for all 20 beds in the CCC including any outliers in the Recovery Unit. One weekend consultant worked in the unit during the day and staff stated that this was not sufficient to lead the

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unit effectively. Several doctors and nurses said that consultants working during the day often stayed into the late evening and sometimes until 2am to ensure patients were assessed and treated.

- The clinical lead had escalated the workload of the on-call consultant due to concerns over them typically being onsite until midnight and returning at 7.30am the next day, whilst being on-call during the night.
- During the day, the ICU had up to two acute care common stem (ACCS) trainee doctors and one specialist registrar with airway skills. The HDU had up to three ACCS or FY2 trainee doctors and two senior house officers. This staffing level was inconsistent and the numbers and grades of doctors changed from day to day and not always in line with patient acuity.
- During night hours, a single specialist registrar was assigned to the CCC, who also carried the bleep for cardiac arrest calls and for sick patients elsewhere in the hospital, this included trauma calls. This meant that the unit was not compliant with ICS staffing guidance for the ratio of trainee doctors to patients of 1:8. Overnight, a four-tier system of junior doctors of grades ST 3 – 5 in anaesthetics could respond to calls from CCC nurses for medical support when the critical care registrar was unavailable. The tier system included a senior house officer or core trainee, an ICU trainee, a doctor assigned solely to observation and a post-Fellowship specialist registrar. All of the night shift doctors were Royal College of Anaesthetist ACCS trainees.
- Doctors stated that occasionally one night shift tier would be uncovered and that locum use was rare, with a consultant occasionally filling a vacant nightshift slot. From looking at planned rotas, there were 20 occasions between November 2015 and January 2016 when one tier would be uncovered.
- Protected training time was allocated to junior doctors on a weekly basis and was overseen by a dedicated audit and teaching consultant and delivered by a specialist registrar. Formal training for junior doctors did not include e-prescribing using the electronic patients' record system, which was provided instead on an ad-hoc basis by the unit's pharmacist.
- The root cause analysis of a serious incident in June 2015 indicated that the lack of capacity for the nightshift registrar to carry out routine patient reviews due to being excessively busy elsewhere in the hospital had resulted in a patient missing an appropriate review of their blood results.

- Recruitment was underway for two to four new consultants however the impact that this would have on night time cover in line with ICS standards was not identified. One member of the nursing staff stated, "There can be moments when I feel that staffing at night is unsafe. Even with a good team there's just not enough, although we never have a night shift without a supernumerary senior sister, which is a huge help."
- When locum doctors were used, they were part of the hospital's internal bank of doctors and external agency locums were never used.
- The team was highly experienced and dedicated. There was a clear enthusiasm for addressing concerns around capacity and medical staffing levels through appropriate channels of submitting incident reports and benchmarking unit data nationally.
- Junior doctors joining the unit in August 2015 received a formal and comprehensive induction. Those joining the unit at other times received an informal induction that consisted primarily of a discussion with a consultant.
- Junior doctors stated they felt very supported by consultants, who they described as "very approachable."

Major incident awareness and training

- Nursing staff had a wide difference in knowledge of major incident protocols. Some nurses were not able to explain it or aware of where to find major incident equipment. One senior nurse said that the trust's major incident lead had cancelled their last study day and this was not rescheduled.
- Major incident awareness sessions had taken place twice in the year prior to our inspection, with staff using call-out sheets and flash cards to allocate roles to individuals as a mock exercise. Staff also tested the emergency cascade process, led by a senior sister, involving anaesthetists, senior nurses and junior nurses. The results of the cascade and call-out exercises had been used to update the unit's emergency contact list, with staff who could respond most promptly to a major incident being prioritised for contact. Nursing staff said they had not been given simulated evacuation training or practice and one individual said that as the unit had only two oxygen cylinders for use in the transport of patients, an evacuation would be slowed by the need to ventilate patients before moving them.
- According to training records, 100% of staff in the unit had undertaken fire training.

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- Consultants said that a major incident rehearsal took place every three years.
- A major incident resource box was located in the matron's office and had recently been updated with action cards and instructions for staff, including key roles and contact lists. The unit's major incident response plan included contact with the East Anglian and Cambridgeshire Critical Care Network to arrange the transfer of patients if necessary to other units in the critical care network.

Are critical care services effective?

Good



We rated critical care services as good for 'effective'.

- Care and treatment was delivered by a competent and well-trained team of doctors and nurses based on a range of best practice guidance, national and international benchmarks.
- There was active engagement with the East of England Critical Care Operational Delivery Network, demonstrating a commitment to expert peer review and service development.
- The mortality rate from June 2014 to June 2015 was consistently less than 15%, representing a lower rate than the national average for similar units.
- Care bundles were audited bi-monthly as part of an on-going system of monitoring treatment outcomes and best practice.
- A dedicated outreach team provided educational support to the critical care complex (CCC) nurses and supported the care and treatment of deteriorating patients in the hospital.
- There were effective systems in place to ensure that staff at all levels understood the need for consent before providing care or treatment and staff had awareness and training in the Mental Capacity Act (2005).

However:

- There were significant gaps in the availability of multidisciplinary input this, most prominently in the lack of a full time pharmacist dedicated to the CCC. Dietician, physiotherapy and microbiology specialists were available on demand but due to low staffing levels did not routinely attend ward rounds or contribute to patient treatment plans.

- The unit did not utilise a rehabilitation tool that assessed short term and long term goals to quantify patient outcomes when they moved into community care.

Evidence-based care and treatment

- Staff conducted a monthly audit of bedside tracheostomy boxes that included the presence and usability of each item of equipment. An audit in November 2015 found 90% compliance. Monthly re audits and reminders posted in each bed space were in place to increase this and on several previous occasions audits indicated 100% compliance.
- A bi-monthly audit of the central catheter care bundle was completed, which included a measure of compliance with seven elements of treatment including hand hygiene, site inspection and catheter access. The most recent results available for May 2015 to November 2015 demonstrated 100% compliance in all observations.
- Bi-monthly audits also took place of peripheral intravenous cannulas, urinary catheters and ventilation-associated pneumonia. Urinary catheter care bundles were found to be 100% compliant with trust standards from May 2015 to November 2015. Compliance with trust standards in the ventilation-associated pneumonia care bundle was consistently below trust standards in the same period, with an average compliance of 66%. Peripheral intravenous cannula care bundle compliance was 100% in the same period in all cases except for November 2015, when it was found to be 75%. The results of the audit and a reminder of standards had been circulated to staff and a re-audit was planned one month later.
- Care and treatment in people with a spinal cord injury was delivered in line with established national and international benchmarks and guidance. This included the use of the Sheffield Spinal Care Pathway and the use of ventilation and respiratory guidelines from the National Spinal Cord Injury Strategy Board. Early reduction and stabilisation of spinal trauma was managed with the use of the American Spinal Injuries Association's Impairment Scale tool.
- Consultants conducted monthly audits of the notes of 30 patients with sepsis following recommendations

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from their participation in a Commissioning for Quality and Innovation (CQUIN) meeting. As a result a new care pathway for sepsis had been drafted and was awaiting approval from the guidelines committee.

- Trainee doctors were each given an audit project to lead when they joined the unit, to contribute to the development of evidence-based and outcome-focused care and treatment. Consultants assigned audit projects depending on the experience of each trainee and quality improvement projects were allocated to trainees based on experience and seniority. Clinical audit projects for trainee doctors had included the use of stress ulcer prophylaxis and bedside tracheostomy kits.
- Critical care outreach team (CCOT) nurses completed local audits of elements of the treatment and care they provided. This included a quarterly audit of the completeness and accuracy of observation records across 27 wards including the recording of early warning scores (EWS). 1236 observation records had been audited from July 2015 to September 2015, with a completion rate of 95% noted and an accuracy rate of 99%. Critical care link nurses and health care assistants (HCAs) from the emergency department were responsible for completing action plans for wards that did not meet recording requirements of EWS. Actions were taken forward, such as an EWS education board in use in the emergency department. EWS link staff wore special lanyards that enabled colleagues around the hospital to easily identify them.
- An appropriate protocol was in place for the placement of nasogastric tubes and for the testing of pH levels. Junior doctors said that radiologists were readily available to provide additional support if needed.
- Staff had identified a lack of clarity in the trust's management of hyperkalaemia in adults' policy during the root cause analysis of a serious incident. This had highlighted that staff would not always respond appropriately to such patients when they presented with certain other clinical indicators because education needed to be more specialised. The CCC did not have an Standard Operating Procedure (SOP) for such circumstances. A draft SOP was awaiting ratification and a plan for compliance monitoring.
- Clinical staff had conducted an audit of rehabilitation pathways against the National Institute for Health and Care Excellence (NICE) clinical guidance 83, rehabilitation after critical illness. Although a rehabilitation plan was captured at admission, the audit

found that the information was not used to modify care, and that a rehabilitation multidisciplinary prescription was not routinely provided. The audit highlighted that physiotherapists quantified physical rehabilitation plans using the Chelsea Tool, which meant that their progress and treatment outcomes could be tracked.

- The unit participated in the East of England Critical Care Operational Delivery Network, which enabled staff to plan improvements to services, practices and outcomes based on peer review against the National Service Specification for Adult Critical Care set by NHS England.
- A critical care respiratory line group ensured treatment was delivered in accordance with the ISO standard for non-invasive ventilation.
- Guidance had been prepared by senior staff for ensuring patient safety when a gastrointestinal bleed or subarachnoid haemorrhage took place. This ensured that control interventions were appropriate according to safety review data published by the National Confidential Enquiry into patient outcome and death.

Pain relief

- Each patient had their pain score assessed during initial assessment and an acute pain team was available 24-hours, seven days. Pain scores were recorded hourly or two hourly depending on the needs of the patient.
- Nurses discussed pain management during handovers and where a change in medicine administration was requested, this was followed up with the consultant.
- The unit had two dedicated pain management link nurses.
- Staff used guidance from the acute pain team to manage pain in patients who were being treated with specialist equipment such as an epidural catheter.

Nutrition and hydration

- Handovers included nutrition and hydration and staff indicated where a person could have small sips of fluid in addition to receiving nutritional support through a nasogastric tube.
- A pathway for the initiation and management of enteral nutrition was in place and was used appropriately. A pathway was used by staff to ensure patients achieved 80% of their caloric target within 72 hours of admission and to establish early nutritional care, in lieu of dietician cover not being available 24-hours seven days. Caloric requirements were assessed using the Penn State University or Ireton Jones equations.

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- Mealtimes in the unit were protected and these were posted on a noticeboard at the entrance to the unit for visitors to note. Relatives were able to join patients during mealtimes if deemed appropriate by the nurse in charge.
- Staff used the Malnutrition Universal Screening Tool (MUST) to determine each patient's risk of malnutrition. This was documented and acted upon in all of the patient records we reviewed.
- Nutritional audits had not been conducted since February 2014.

Patient outcomes

- The unit contributed data to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. The unit performed better than the national average for hospital mortality in the 2014/15 ICNARC audit.
- Rates of patients who were discharged and then readmitted within 48 hours was slightly higher than other similar units, at less than 2% in all months but one from June 2014 to June 2015.
- An appropriate member of clinical staff completed a rehabilitation plan for each patient when they were admitted. This was repeated after a patient had been on the unit for four days and if they were still on the unit after ten days, a multidisciplinary meeting was scheduled with a critical care consultant and other specialists who were providing treatment for the patient.
- Staff were preparing to introduce the NHS Institute of Innovation and Improvement acute trigger tool to measure the unit's incidence of harm.
- An incident investigation had identified that the unit did not have a standard operating procedure (SOP) in place to ensure patients were stable enough to be transferred. Additionally, there was no SOP in place to ensure the safety and treatment of patients without an arterial or central line insertion overnight, because routine bloods were only taken from such patients when nurses were both trained in this and had time to do so. An audit of 10 patients in August 2015, around the observation documentation used during patient transfers found compliance to be 68%. The recording of patient temperature was the most often omitted detail. The clinical leadership team had responded to this by

implementing new transfer records for staff to complete and issuing reminders to all staff of the need for consistent documentation and recording of patient observations.

- The unit did not utilise a rehabilitation tool that assessed short term and long term goals to quantify patient outcomes when they moved into community care. This was acknowledged in intensive care standards compliance documentation and the senior clinical team was exploring the adoption of the Manchester Mobility Score tool to address it.

Competent staff

- A dedicated Clinical Nurse Expert (CNE) had been recruited to the department who would develop the unit's training programme. Prior to this appointment, a senior band seven nurse in the department had taken the lead for training and nurse development as an interim CNE. This member of staff was a non-medical prescriber and was also studying a related Master's degree, offering a high level of competence-based support to more junior staff. They had organised and delivered in-service training days such as a medicine management programme with the unit's pharmacist. Bedside teaching took place regularly in the unit and we saw that senior nurses were supportive of junior nurses in helping develop their skills and knowledge.
- The interim CNE had prepared a series of case studies of events in the department that could be used for staff development and education. For example, case study sessions had included managing patient discharges, managing the admissions process, addressing problems with epidurals, risk assessments for treatment withdrawals and the use of cytotoxic drugs. Nursing staff were enthusiastic and gave positive feedback in reference to training. One nurse said "Because the training is based on things that have actually happened, they're also a chance for us to talk openly about our practice and what we could do better."
- New nurses were supported to develop their role in the unit by a senior team receptive to their needs. For example, a recent new intake of nurses had indicated that they would like more experience in supporting registered nurses with intubation. The interim CNE had established a collaborative programme with CCC doctors that used simulation exercises to support them

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in building confidence and ability with intubations. Simulations were followed by debriefs between all of the staff involved, which were used to highlight areas of good practice and areas for development.

- The interim CNE had developed training that included other specialty services such as a paediatric training day for nurses, with the paediatric link nurse and a paediatric consultant. The training had included a simulation exercise and positive feedback from staff had led to the development of training session led by the paediatric safeguarding team. Additionally, a palliative care nurse ran monthly targeted training days and had also attended CCC team study days to deliver specific training on end of life care. Study days for ventilation, cardiac care and hemofiltration had also taken place, representing a range of programmes for nurses to follow to develop their practice and their link role.
- At November 2015, training compliance in key areas was; equality and diversity 96%, information governance 94%, resuscitation 94%, blood transfusion 86%, blood collection 100%, health and safety 99% and VTE assessment and care 92%.
- Training time was protected if staff were nearing expiry and were allocated to training sessions as part of their working rota to ensure they were not removed from training for clinical purposes. Nurses we spoke with told us that training days covered treatment practices that were relevant to the CCC and reflected recent incidents or the needs of recent patients.
- A mentorship programme was in place for new and developing nurses and was led by a dedicated band seven nurse who maintained a mentorship register of those with appropriate certification.
- Senior band six and seven nurses were trained in Advanced Life Support and European Paediatric Life Support and staff nurses had been trained in Intermediate Life Support and Paediatric Life Support.
- A rolling programme of secondment for band six nurses was in place that enabled ICU nurses to join CCOT to develop their skills in relation to the management of deteriorating patients. This team was trained in taking blood gases, venepuncture and was staffed by trained nurse prescribers.
- Nurses said they could ask for additional training or tuition whenever they wanted and this would be provided, such as recent brain stem testing training.
- Training days held by CCOT nurses were evaluated by attendees, which generated consistently positive feedback
- There was an induction and supervision process in place. For three weeks nurses were supernumerary and were buddied with experienced colleagues to give them the opportunity to learn from people with a range of specialist skills. One band five nurse stated that they had been buddied with two colleagues and worked the same shift patterns with them to help them understand unit processes and policies in detail.
- Nurses stated that they received a professional development plan on starting the CCC but did not receive regular clinical supervision after this, although senior staff would provide supervision on request. Nine-month preceptorships were offered to qualified nurses, which included being buddied with another nurse in the unit on each shift.
- 63% of nurses had received an appraisal in the twelve months prior to our inspection. The appraisal process had been transferred to an electronic system that enabled staff to reflect on their experiences and development before the appraisal meeting. The appraisal structure used the trust values and vision as a framework and staff said they felt it was very “people-focused.” One nurse said, “The appraisals are very positive. They’re used to help us respect each other and to focus on learning for the whole of our career.”
- 60% of nurses had undergone post-registration certification in critical care, which exceeded requirements set by the Royal College of Nursing.
- Nurses were reminded of revalidation dates using a communication book and this was also discussed during handover. This form of communication was used to update all nursing staff on policy changes and nurses at band six and above additionally attended monthly meetings to discuss them.
- There was a positive culture of promoting good working practices between nurses and doctors. This was through the use of specific training in competencies such as communicating bad news to patients and relatives, which different staff grades attended together. The clinical director said that nurses routinely came to him prior to their intensive care training courses to ask for explanations of procedures.

Multidisciplinary working

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- One CCOT nurse staffed the outreach service per shift and the workload of this team was reflected in the unit's risk register.
- CCOT nurses were able to schedule responsive meetings with ward nurses and staff to address local issues with the identification and treatment of deteriorating patients.
- A consultant in the CCC acted as a liaison for CCOT if medical input for a patient was needed. Nurses felt supported by consultants but the process was time consuming, as the critical care consultant had to make contact with the patient's own consultant before treatment could be progressed.
- The H@N team received a handover from the CCOT nurse each evening and then handed over to a CCOT nurse the next morning. This process was structured, with detailed printed information given to the team or member of staff taking over which included patient location, diagnosis, EWS score and their priority for a review.
- The lead CCOT nurse had established a resuscitation and unwell patient committee that was led by ratified terms of reference and that was responsible to the hospital's clinical safety board.
- The unit's pharmacist was a dedicated and highly valued member of the CCC team and contributed actively and significantly to ward rounds. The CCC team spoke positively and without prompt about the value that this individual contributed to the unit.
- The dedicated pharmacist had not been assessed against recognised practice frameworks of the UKCPA, RPS or Department of Health. This meant that the unit was not compliant with FICM core standards with regards to clinical pharmacists.
- Staff were able to refer patients to the mental health team rapidly when needed, such as when a patient was admitted with a recreational drug overdose.
- CCOT nurses were able to refer to specialist community nurses for patients post-discharge, including a tracheostomy nurse. Tracheostomy specialist nurses were not available in the hospital on a weekend and CCOT nurses additionally took on this role for urgent referrals in the hospital.
- Staff said that physiotherapists rarely attended ward rounds due to workload but that they would attend on request for a specific patient. Although physiotherapists and critical care nurses worked closely together, patients did not always receive the 45 minute standard of rehabilitation required due to short staffing in the physiotherapy team.
- Consultants led daily ward rounds but there were ongoing problems in achieving a consistent multidisciplinary attendance. For example, the unit had pharmacy cover on a two hourly basis, five days per week. This meant that ward rounds did not always have a pharmacist present. The unit did not have a dedicated dietician and this meant that ward rounds often did not include dietetic input. Available dietician input was below the standards established by the British Dietetic Association. During one of the ward rounds observed an ear, nose and throat (ENT) consultant attended specifically to communicate about a critical care patient and to request that their clinical input be included in the patient's electronic record.
- The ward round was due to start at 9am each day but this was frequently delayed because the consultants was occupied with trying to improve patient flow when the unit was full or if patient discharges were being delayed. On the ward round we observed, the specialist registrar attended late, as they were also required to attend the anaesthetic clinical governance meeting. There was no standardised process to ensure regular attendance of designated staff on the ward round when clashes with other commitments occurred.
- Documentation that ward rounds had taken place twice daily were inconsistent in electronic patient notes and it was not always clear that a patient had been seen by a consultant twice per day, although in practice this was happening.
- As part of the root cause analysis of a serious incident, it had been identified that separate nurse and doctor handovers, and a lack of standardisation of the information discussed during handovers contributed to a significant miscommunication between staff. The action plan from this investigation indicated that this issue had been rectified in October 2015 however doctors and nurses discussed patients together during ward rounds but not systematically and handovers were conducted separately.
- The consultant we observed lead a ward round was thorough and systematic, examining each patient thoroughly and discussing his or her full history. The ward round was attended by three trainee doctors, a clinical fellow, a specialist registrar and the unit's

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pharmacist. The pharmacist was involved with the treatment plan for each patient and demonstrated a detailed understanding of each individual. Nurses were not consistently present in ward rounds and the matron and senior supernumerary nurse in charge observed patient discussions intermittently due to workload.

- Psychiatric liaison nurses were available during daytimes and an out-of-hours on-call service operated at other times.
- Input from the SaLT was not offered routinely but they were available five days per week and staff told us they were responsive and helpful when needed.
- The lead consultant highlighted the need for training of emergency department staff around the role of the night-time CCC specialist registrar. This was to avoid lengthy and inappropriate call-outs before the emergency consultant has conducted their own assessment. Guidelines for staff on this issue were not finalised at the time of our inspection.
- A local staff audit found that a robust mechanism for documenting and monitoring the input of multidisciplinary patient liaison therapy services was needed to ensure rehabilitation care followed NICE guidelines.
- A nurse handover took place twice daily that was also attended by the duty CCOT nurse. The relationship between the two critical care teams included an educational and teaching role. An outreach nurse had been shortlisted for an annual education award for their effective use of simulation training.
- A consultant anaesthetist led twice-daily handovers between registrars and other trainee doctors. We observed two handovers which were structured with the use of appropriate handover documentation, well led and included a discussion of test results, treatment plans and the plan for critical care outliers in the emergency department and in wards. Consultants had a teaching focus during handovers and that junior doctors were encouraged and supported to be involved, particularly in establishing the plan for each patient. One handover discussed a problem with capacity in the unit in relation to patient acuity and staffing. Staff worked collaboratively to ensure patient safety was maintained by securing the support of nurses working in theatre recovery.

- Multidisciplinary team meetings were documented in patient electronic records and included a summary of the meeting, a review of significant events and an updated treatment plan.

Seven-day services

- The Speech and Language Therapy (SaLT) team was available during daytime working hours Monday to Friday and could take part in ward rounds on request but staff stated this was not guaranteed or standardised. An internal audit had highlighted a lack of seven-day services including pharmacy and dietician cover.
- A pharmacist was dedicated to the unit but was contracted to 0.2 of a full time equivalent, which equated to two hours per day and included dispensing responsibilities. This meant that in-unit pharmacy cover was not always available and outside of these times staff had to contact a pharmacist elsewhere in the hospital. Pharmacist cover did not meet the core standards for intensive care units of the Faculty of Intensive Care Medicine (FICM) or the guidance of the UK Clinical Pharmacy Association (UKCPA) and the Royal Pharmaceutical Society (RPS). To address this, a business case for a full time pharmacist had been submitted and was awaiting a decision.
- A local audit of compliance against NICE clinical guidance 83, rehabilitation after critical illness, highlighted that there was physiotherapy assessment and treatment provided seven days per week.

Access to information

- CCOT nurses had access to patient history when they reviewed notes on the wards but stated that 'see and treat' notes for the H@N team would help them to review observations and management plans more efficiently during the day.
- The electronic patient records system stored medical histories of patients seen previously and this information was readily available to clinical staff. This could be provided on demand to other treating professionals and to primary care staff when a patient was discharged.

Consent and Mental Capacity Act

- Patient electronic records included a space for the daily assessment of mental capacity as defined by the Mental Capacity Act (2005) (MCA). Each patient had a mental capacity assessment but this had not always been

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completed on each shift. A prompt to consider the MCA was on every page of the electronic records system and mental capacity guidance from the Office of the Public Guardian for MCA was readily accessible.

- If a patient with a Deprivation of Liberty Safeguards (DoLS) authorisation was admitted, this was noted in their electronic record. Trainee doctors stated they were aware of a safeguarding lead to contact for support but said they had not undergone formal training about DoLS.
- Staff had access to a team of independent mental capacity advocates who they engaged with to conduct best interests assessments for patients with high levels of clinical risk and complex mental health needs.
- Where a patient was admitted with a Deprivation of Liberty Safeguards (DoLS) authorisation in place, staff arranged a meeting with the safeguarding team if the patient was still in the unit after four days in accordance with internal policy
- Staff cared for patients with mental capacity needs or a DoLS authorisation according to established guidance, including the Department of Health DoLS Guide for Hospitals and Care Homes (2009) and the European Convention on Human Rights Article 5. Under this guidance, consent to treatment was obtained according to trust policies, including a DoLS code of practice and an MCA code of practice.

Are critical care services caring?

Good



We rated critical care services as good for 'caring' because:

- Staff had a natural ability to adopt compassion and empathy in their communication.
- The social care needs of people were taken into consideration by staff who showed awareness of the additional risks to mental health and recovery for those patients without local family
- Personalised care was offered to patients, particularly those who remained in the unit for longer than four days. This included help with personal hygiene and a record of the patient's preferred daily routine.

- Relatives and visitors had access to emotional support from team members who demonstrated an acute awareness of the anxiety and worry that a stay in critical care could cause.
- Information on independent community support groups was readily available and staff were able to offer help through the use of a follow-up clinic and a bereavement service.
- Quiet and private areas were available for relatives and visitors.

Compassionate care

- There was an embedded, positive attitude towards compassionate care that was demonstrated by all levels of staff. Staff referred to compassion naturally when discussing patient treatment and recovery plans. For example, during a nurse handover, staff commented that a patient had been admitted looking unkempt and they had been unable to find a next of kin. Staff discussed how they could make the patient comfortable in the unit by being aware they had social care needs.
- Staff working on a 1:1 basis with ICU patients were aware of the effects of delirium or distress and were able to offer appropriate reassurance. For example, a patient who had been noted in a nurse handover as being confused overnight tried to climb out of their bed, which would have been unsafe. The patient's nurse noticed immediately and gently calmed them by sitting next to them and lifting their oxygen mask slightly so they could communicate more easily. This had an immediate and positive effect on the patient.
- Staff had introduced patient diaries for those in the unit longer than four days the benefits of which had been considered at a divisional governance meeting.
- The nurse lead for the electronic patient records system had adapted a palliative care rounding tool that staff used to structure observations and assessments and improve patient experience. This included checks of psychological, spiritual and social needs and included a record of the outcomes of discussions around the patient's preferred place of death. The unit routinely engaged with the Palliative Care Adult Network guidelines to ensure end of life care pathways were robust and appropriate. The unit had four dedicated end of life link nurses.

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- A large number of thank you cards received in the unit were on display for people to read. Comments included, “Felt nursing care was excellent and having a chair wash made such a difference.”

Understanding and involvement of patients and those close to them

- Staff readily and naturally included a discussion of their understanding of patient needs beyond critical medical treatment during nursing, medical and CCOT handover. This included a discussion of how to facilitate accommodation for a family who had spent the night in the unit with their relative and confirmation that staff had contacted a person’s family who was admitted overnight.
- Consultants involved patients who were awake during the ward round, they explained technical medical information to them in a way that was understood.
- Nurses were able to provide support and understanding for relatives of patients with complex needs that family members wanted more information about, such as HIV and hepatitis.
- Where patients remained in the unit for longer than seven days, a dedicated lead consultant was allocated to the patient and their family to ensure consistency of information and support.
- A senior band six nurse led a weekly follow-up clinic for patients who had been in the CCC for four days or more. Patients and their relatives were offered the chance to come into the hospital to meet the multidisciplinary team that cared for them, including a nurse, critical care consultant and physiotherapist. Other specialities, including speech and language therapy and physiotherapy, were available if needed but staff stated that it was often not possible to obtain a psychologist or occupational therapist.
- There was a large waiting area with a private section screened-off as well as a separate quiet room that relatives could use. Although the waiting area had designated opening times, relatives could use these spaces whenever they needed to. The unit did not have designated overnight accommodation for relatives but staff were able to facilitate overnight stays for relatives, such as letting them stay at the bedside or in the side room of their family member. Relatives had access to a kitchen area and food storage to help them remain in the unit with access to food and drink.

- Relatives said that they had been involved appropriately and proactively by doctors and nurses. One person stated, “I was happy that the doctor actually came looking for us to have a chat about our relatives condition. It gave me a lot of confidence that the staff here genuinely care.”
- We observed a CCOT nurse discuss a patient’s discharge with them, including a clear explanation of what their medicine was for and how it would help them.
- When a patient was in the unit for four days or more, staff encouraged the use of a diary. This recorded significant events during the patient’s stay and could be completed by the patient, their care team or relatives. It was used to help the patient to understand their stay when they were discharged and formed an important part of discussions at the follow-up clinic.
- Staff had developed a resource to use with patients who stayed in the unit on a long-term basis that helped them to record and understand their likes, dislikes and daily routines. This had been in response to a patient who had stayed in the unit for over three months and meant that staff could provide personalised care in addition to medical treatment.

Emotional support

- Relatives of patients in the unit spoke very positively about their experiences of support. One relative described nurse support as “brilliant” and another said, “Nurses have been happy to talk to me by phone at any time of day or night since my relative was admitted.”
- Staff had highlighted that psychological support for patients and their relatives as part of rehabilitation pathways was limited in scope, and that a patient and relatives support group was not available. The audit found that a consultant occasionally made post-discharge contact with patients’ GPs, but this was not a standardised process to ensure support was available.
- CCOT nurses spoke to people on the wards in clear language and with kindness. For example, one patient who had been deteriorating and had begun a recovery, was reassured by a CCOT nurse who took the time to explain what their observations meant and why they considered this an improvement.
- Two nurses ran a bereavement support group and wrote to the family members of patients who had died in the unit. In consultation with the team who had provided care to the patient, relatives were called approximately

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two months after a patient's death. This was used to offer emotional support to relatives and could signpost them to independent specialist community services for emotional and counselling support.

Are critical care services responsive?

Good



We rated critical care services as good for 'responsive' because.

- Staff worked to ensure the individual needs of people were met, including those experiencing barriers to communication and learning difficulties.
- Staff used adapted tools such as iPad software and Makaton prompts in a communication book to improve their ability to communicate with people who could not speak.
- All of the registered nurses in the unit had at least one link role that enabled them to focus their professional development on a specific area of patient need such as dementia, diabetes or HIV.
- New processes had been introduced by the matron and operational manager to reduce the number of delayed discharges and out of hours transfers.
- A structured, time-sensitive system of multidisciplinary bed capacity meetings took place each day, led by a senior member of the team and involving the operations centre bed manager. This had helped to improve flow through the unit and more appropriate use of staff time.

However:

- Although an escalation plan for bed capacity was drafted, it was yet to be ratified.

Service planning and delivery to meet the needs of local people

- Three specialist nurses in organ donation worked within the CCC and were "very involved" in discussions with patients and relatives. A trust organ donation team attended mentor team days in the unit to speak with new staff about their role and purpose.
- Staff used organ donation guidelines established by National Institute for Health and Care Excellence (NICE) and the NHS Blood and Transplant Special Health Authority to speak with patients and relatives about organ donation processes.

- Nurses were able to refer people to community support organisations specific to their health condition or mental health state if needed, often as a result of follow-up clinics. Patients who attended a follow-up clinic were asked if a summary of the discussion could be sent to their GP.
- Staff had an acute awareness of the health needs of the local population that were lifestyle, addiction or behaviour-related. For example, the nursing lead for the electronic patient records system had established an active link to the National Poisons Information Service to assist staff with toxicology assessments.
- The unit did not have access to a regional home ventilation and weaning unit.
- Nurses had taken on link roles that helped the unit to meet the complex needs of patients, including those with learning difficulties, HIV and diabetes.

Meeting people's individual needs

- Patients were assessed for their level of delirium by staff who used the Confusion Assessment Method (CAM) and the Richmond Agitation Sedation Scale (RASS). An internal audit in November 2015, had found that 11 out of 16 patients had their delirium score assessed in the previous 24 hours, which was not compliant with NICE guidance.
- Where a CCOT nurse saw a patient on the ward, a handover was given to the patient's named nurse and documented as such. CCOT nurses used the ABCDE system standardised by the Resuscitation Council when assessing and documenting patient observations on the wards. We saw that this system was in use across the CCC.
- Neurological rehabilitation was provided in the CCC and on another designated ward, where physiotherapists were able to provide care.
- Staff in the unit had considered how to meet the broader needs of people that would contribute to their recovery, beyond the critical medical treatment they needed. This included the provision of five iPads that could be used as communication tools for patients who could not communicate verbally. A member of staff had designed and built a custom-made 'arm' that could be safely attached to a bed and used to hold the iPad in an elevated position. This helped patients with a spinal injury to use the devices for entertainment, which helped to reduce anxiety and boredom.

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- Staff were formulating a business plan to source specialist software for use in the department that would enable patients who did not have the ability to communicate verbally to engage with the software and have full conversations with staff.
- Patients had their levels of sedation scored and adjusted according to (Intensive Care Society) guidance.
- Rehabilitation assessments included a stepped care approach that used NICE clinical guidance 22, 23 and 26 to ensure patient needs in relation to anxiety; depression and post-traumatic stress were effectively managed. Staff had developed the guidance after treating patients who had needs relating to low self-esteem and body image issues and relationship difficulties.
- The CCC had access to a learning disabilities liaison nurse and a nurse in the unit was a designated link to learning disabilities services.
- A 'hospital communication book' was used to help staff communicate with patients who could not speak or those with learning disabilities. This resource included visual aids such as pictures of symptoms that patients could point to, pictures of procedures that staff could use to obtain consent and explain what they planned to do as well as Makaton signs to help staff communicate using that technique.
- Staff had given thought to the environment of relatives and visitors to help them understand the critical care unit. This included leaflets available to explain the types of care and treatment most often given in the unit, as well as the various roles of staff. This included a colour-coded sign to help people identify the grade and role of each staff member. Staffing levels were clearly displayed at the entrance to the unit and indicated if staffing levels were below or above those planned. The nurse in charge was identified for both the ICU and the HDU.

Access and flow

- Between August 2014 and July 2015, critical care bed occupancy for adult beds was reported to be 100% on two occasions.
- In 2014/15, 63.6% of patients had their discharge delayed by over four hours, which was most often due to the lack of available beds elsewhere in the hospital. This was documented on the unit's risk register and the matron was the designated lead to work with other departments to reduce delays. In the same period, 8.5%

of patients were discharged to a ward out of hours between 2200 and 0700. Where this occurred, it had been recorded as an incident and the site manager advised prior to discharge.

- There was an escalation plan for staff to use when the unit was full to capacity and beds were needed for new patients. This was in draft form and had not been ratified by the trust's executive board. The divisional director told us verbally they supported the plan. Elective patients for the HDU could be treated appropriately in theatre recovery overnight and the critical care consultant made the final decision regarding this. The clinical lead told us that recovery beds were used once every four to five days on average.
- The operational manager reported six times daily to the hospital's operations centre with details of bed capacity and patient flow to assist with the planning of patient admissions and discharges.
- Senior nurses said that issues relating to access and flow were a significant challenge for the unit due to general lack of capacity across the trust.
- Three times daily reviews by the critical care matron and surgical bed manager took place to assist CCC staff with patient admission, transfer and discharge. Senior sisters in the unit acted as links with hospital bed managers the escalation policy to the operational manager was used appropriately. Additionally, the HDU and ICU sisters and consultants, the CCOT senior nurse and a physiotherapist held a morning multidisciplinary capacity meeting. Such improvements in the management of access and flow were intended to reduce patient admission and discharge delays and to manage the process with dedicated staff who received consistent support from the senior management team.
- Consultants stated that as other services in the hospital had expanded, they felt that excessive pressure was put on them to take elective patients even when the CCC was full. When this happened, two patients could be cared for in theatre recovery. Where CCC patients were treated in theatre recovery, they were cared for by the CCC medical team. Recovery nurses with a post-registration critical care certificate were assigned to critical care patients in a recovery bed.
- Doctors stated that elective patient admissions were cancelled frequently. They attributed this to the lack of capacity in the CCC and the lack of a coherent escalation policy that included direction for staff in the

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cancellation of elective patients. The most recent data available during our inspection was for September 2015 and indicated that of seven elective patients planned for admission, five had been cancelled due to a lack of beds.

- Staff in the CCC used an electronic capacity monitoring system that was in place across the trust and enabled them to plan admissions and discharges more effectively.
- The CCC was used as an 'unofficial' trauma centre and that critically ill patients could be accepted from the air ambulance service with the exception of neurology or cardiac emergencies.
- Discharge documentation was comprehensive and a CCOT assessment was completed in advance when a patient was discharged to a ward. A doctor would also contact the doctor on the patient's destination ward to discuss their treatment and this was documented in the electronic records system.
- A dedicated ward clerk was available Monday to Friday in the CCC but at weekends, nurses covered this function.

Learning from complaints and concerns

- A large, bright and well-maintained relatives waiting room was available and included information leaflets on CCC procedures and policies including single sex accommodation, patient diaries, the bereavement service and follow-up clinic. Confidential feedback forms were provided that asked people for their views on cleanliness, patient care and communication from staff. Vending machines were available for drinks and snacks as well as an accessible toilet and display of changes to facilities following feedback from patients and their relatives.
- Formal complaints in the unit were referred to the hospital's legal team in accordance with the trust's policy. Band four and five nurses said they had not received complaint training and were told to defer to the senior nurse on duty in all cases, which meant that junior staff were not involved and felt some detachment with learnings from complaints.
- All staff stated that the Patient Advice and Liaison Service (PALS) was very good and they could provide their contact details.
- Between January 2015 and September 2015, the unit had received five formal complaints.

- A designated band six nurse was the lead for investigating and resolving complaints, including whether they were formal and informal. There was a transparent and proactive approach to resolving complaints. For example, an initial phone call to the complainant took place and the lead nurse invited them to a meeting to discuss the issues raised. It was the unit's policy that formal complaints were escalated to the Patient Advice and Liaison Service, which complied with the NHS England complaints procedure.
- Feedback from complaints was discussed at monthly governance meetings and the outcomes discussed during daily handovers.

Are critical care services well-led?

Good



We rated critical care services as good for 'well led' because:

- Recent improvements in the clinical governance structure and the formation of an acute care forum meant that accountability for change and improvement was being established,
- Leadership from the matron, senior nurses and consultants was coherent and they worked within an embedded culture of support and professional development in an environment that was frequently challenging.
- Staff spoke positively about a recent stabilisation of the clinical team following the appointment of a new matron and operational manager
- There was a good working relationship within the multidisciplinary team

However:

- There was a lack of coherence around the links between divisional executive leadership and senior staff in the unit concerning the vision and strategy of the service and how risks were managed and resolved appropriately. The appointment of a risk manager was intended to address this to some extent but this strategy was not clearly identified or planned.
- The use of a risk register indicated that unit staff had an effective system in place for identifying and escalating

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causes for concern. However there was inconsistent communication when incidents had been acknowledged, reviewed and acted upon by the senior divisional team.

Vision and strategy for this service

- The vision for the service from the perspective of senior staff was to expand capacity and to improve the structure of the governance system. This was to ensure risks highlighted by staff were more appropriately considered and assessed. As part of the preparation for this, a risk manager had been appointed to assess the risks associated with doctor staffing levels that had been highlighted by existing staff.
- Staff discussed the plans for the expansion of the unit, although there was little consistency in understanding of these. For example, the divisional director and associate medical director described the expansion plan as “fluid” and explained that they did not want to compromise existing clinical space in the unit.
- Some clinical staff said that data had been presented to the chief executive that demonstrated the unit’s lack of capacity, but that these had been dismissed and there were no plans to expand. Another clinician thought the expansion plan should be a priority due to the increase in high-risk surgery taking place in the hospital, and the lack of Critical Care Complex (CCC) expansion since 2002. Staff also felt that until the unit’s medical staffing was increased an expansion would not be appropriate.
- Other staff were not clear on the vision and strategy for the service. One nurse said that they understood the trust vision but felt it hadn’t been clearly applied to the CCC. They stated that corporate-level communication relied mostly on e-mail for delivery and as such was ineffective.
- Senior nurses described a disconnect between the trust executive team and critical care consultants as a result of poor communication about unit expansion plans.

Governance, risk management and quality measurement

- The operational manager, clinical lead, consultants, CCOT nurses and senior CCC nurses had established a new clinical governance structure. Staff were reassured by this improved structure, particularly because it

clarified lines of accountability within the senior executive team. Responsibilities for the operation of the department were more evenly allocated because of the new governance structure.

- Minutes of governance meetings showed that coherent action plans were used to establish lines of accountability for changes in policies and practice and these were tracked at subsequent meetings. For example, action had been taken to update obsolete policies, improve the quality of handovers from junior medical staff and expedite the draft capacity escalation policy.
- Staff felt that historically the CCC had not been heard by the trust but this was improving. For example, in September 2015 at a critical care governance meeting, a decision was made to re-categorise an incident as a serious incident taking into account the outcome of a morbidity and mortality (M&M) review. The decision was made with the approval of the medical director or the risk management team and demonstrated the function of clinical governance in safety and learning from incidents. The action plan implemented as a result of the incident investigation demonstrated that information sharing, education and trust policies needed to be improved in the management of hyperkalaemia when specific comorbidities were present.
- Attendance at the new clinical governance meetings had been unpredictable in the first four months and that despite offering to pay nurses to attend during time off, nurse representation remained low.
- An acute care forum had replaced a critical care delivery group with the remit of discussing issues relating to deteriorating and critically ill patients in a multidisciplinary, structured forum. The CCOT lead nurse had drafted a terms of reference for the forum and these were awaiting ratification at the time of our inspection.
- Issues arising from clinical governance meetings were disseminated to junior doctors by e-mail, but that the effectiveness of this was yet to be determined as they were not dedicated CCC trainees, but were working in the unit as part of their rotation on a temporary basis.
- We reviewed minutes for the previous three clinical governance meetings. In each case, clinical education had been discussed based on deaths in the unit and

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that complaints were always included. The low level of medical staffing overnight and staff perception of the unit's increasing struggle to meet demand was a consistent central agenda item.

- The critical care governance group reviewed all paediatric patients seen in the CCC and supported investigations based on reported incidents.
- A risk register tracked risks that had been identified in the unit. The most significant risk identified by staff was the lack of doctors on the unit during the night. The clinical lead had submitted a risk assessment relating to the risks to patient safety as a result of this, relating to consultants working more than 12 hours continuously, being responsible for up to 20 patients at one time and the risks associated with relying on inexperienced junior medical staff out of hours.
- The divisional communication risk team had contested the risk rating given by the consultant and had reduced the risk calculation as a result. Medical staff were concerned that this had been downgraded. There was a lack of consistent agreement between senior staff, which meant that we had concerns that the existing trust-wide governance system was not robust enough to address the risk appropriately. The lead for clinical governance in the CCC said that nurse staff shortages were generally prioritised but that the risk of low medical staffing out of hours was not and remained in situ.
- A risk manager was in post for the unit but the divisional director was unable to clarify how this role had improved safety or reduced patient risk. There was no evidence provided that accounted for the rejection of senior clinician incident reports and risk assessments regarding staffing issues such as the medical staffing concerns overnight and the lack of a full time pharmacist
- Lack of capacity and delayed discharges from the unit were seen by the divisional director and the associate medical director as a clinical issue. There was no evidence that the consultants in the CCC were being supported to reduce the instances of delayed ward rounds when they were occupied with improving patient flow.
- An internal check of CCC standards against those of the ICS had found that levels of cover from consultants, junior doctors, pharmacy, physiotherapist, dietetics and speech and language therapy (SaLT) support did not meet recognised benchmarks.

- There was a disconnect between senior staff and the executive team that meant that there was a concern that whilst reporting of incidents at a local level was in place, there were inconsistent communication when incidents had been acknowledged, reviewed and acted upon by the senior divisional team. Locally the team had raised incidents regarding safe staffing but these had not been responded to effectively or communicated clearly.

Leadership of service

- There was a lack of clear connection between the division's executive team and the senior clinical staff in the unit. There was a lack of clarity in incident and risk reporting and escalation processes, particularly in relation to a lack of medical staffing and the lack of coherence in how the unit maintained safety when it was full.
- Leadership from the executive team was not always identifiable in the unit and there was a lack of coherence in individual understanding of the management and governance of the service. For example, the consultants and senior staff we spoke with about the future plans for the service and risk management.
- Senior nurses were able to develop their management, leadership skills and competence because there was a robust system of support and training in place, including training related to staff management such as appraisals and sickness absence. For example, each band seven nurse took responsibility for up to 12 junior staff, including HCAs and administration staff. The annual appraisal included support with each individual's professional development plan.
- There were monthly consultant meetings and that issues were subsequently discussed with the deputy clinical director. The meetings were not minuted which meant we could not verify if there were actions or outcomes that improved care and treatment.
- Leadership on a daily basis in the CCC was coherent, clearly structured to focus on patient outcomes and staff spoke highly about safety. Positive and mutually supportive relationships existed within and between the nursing and medical teams and junior staff we spoke with told us how well motivated they were. The matron, senior sisters and the consultants were described as,

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“accessible and approachable” by junior staff. From our observations clinical leadership was strong and enabled staff to deliver a good standard of care despite the challenges of capacity, flow and staffing levels.

Culture within the service

- Staff at all grades felt supported, knew who to approach to raise an issue and that all staff were open to improving their practice and learning from each other. One nurse said, “The departure of our previous matron was sudden and unexpected but the new matron has stabilised the team although I’m worried she’ll leave within the next year. The relationships between nurses and consultants are very good. The junior doctors change a lot but are very approachable.”
- The supportive working culture was highlighted as a recent positive change, following a period of low morale and instability. A senior nurse said this had considerably improved after the appointment of the new operational manager who they described as, “visible, involved and approachable.” We saw further evidence of this in the greeting cards received in the unit from staff who had left. One former member of staff had written, “This is the warmest and most welcoming team I have ever worked with.”
- Healthcare assistants provided a support role in the CCC. A healthcare assistant said that they were offered flexibility in their working hours and that the unit was, “a lovely place to work.”
- Staff stated that there was a problem with security on the unit. For example, junior doctors shared lockers and told us that because of the lack of availability, they often had to leave valuables in the staff room, from which there had been three thefts in the past year. We did not find evidence that the thefts had been investigated or that corrective action had taken place.

Public and staff engagement

- The matron maintained active and open communication with senior band seven nurses, part of which involved twice-weekly meetings. A band seven nurse said that this worked well as a supportive strategy. They said, “[The matron] tells us everything that’s going on in the unit and I feel really optimistic as a result.”
- The matron and operational manager were establishing a more coherent development plan for the unit and involving staff in this. For example, the trust’s broader vision was being adapted to the CCC by asking staff what they understood by it and what it meant for their role.
- New band five nurses had been involved in discussions with band seven nurses to plan how nurses could be developed professionally. The matron said that they were involving nursing staff in how established staffing levels would be planned to meet RCN guidance in the future.

Innovation, improvement and sustainability

- Staff engaged readily with students in the unit. Medical students stated that a three-day programme that included time with the CCOT team, in HDU and in ICU was valuable and allowed them to observe audits and shadow nurses and trainee doctors. Consultants recognised medical students as an important part of the future sustainability of the unit and actively involved them in ward rounds to support their experience and confidence.
- The student nurse mentorship programme enabled students to undertake observations and training following critical care standards of the NMC that supported their learning and practical development.

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Safe	Requires improvement	
Effective	Requires improvement	
Caring	Good	
Responsive	Requires improvement	
Well-led	Requires improvement	
Overall	Requires improvement	

Information about the service

Maternity and gynaecology services for Norfolk and Norwich University Hospitals NHS Foundation Trust (N&NUHFT) were provided at Norwich University Hospital

There were a total of 61 maternity beds and the trust reported a total of 5,853 deliveries in 2015.

Services available to women included home birth, a consultant led, 15 bedded delivery suite, a midwifery-led birthing unit, antenatal clinics, a fetal medicine clinic and a postnatal inpatient ward. Cley ward was a shared obstetrics and gynaecology ward, which also provided an obstetric assessment Unit (OAU) / triage facility and a pregnancy assessment and wellbeing suite.

Community midwives (CMW) were employed by Norfolk and Norwich University Hospitals NHS Foundation Trust. They worked in nine teams across a wide geographical area, providing midwifery care and a home birth service in partnership with general practitioners (GPs), health visitors and children's centres.

There were 22 gynaecological inpatient beds, a gynaecological outpatient area, and an early pregnancy assessment unit (EPAU) unit and the Arthur Smith assessment unit.

During the inspection we visited all the wards and departments relevant to both services. We spoke individually with 18 midwives and 17 nurses, and held focus groups for both nurses and midwives where they were able to express their views as a professional group. We also spoke with 30 medical staff, and nine

administrative and managerial staff. In the maternity service we spoke with 11 women, eight of those with their partners, and in the gynaecology department we spoke with 10 patients.

We reviewed 34 sets of records and six prescription charts across both services, along with information requested by us and provided by the trust.

Maternity and gynaecology

Summary of findings

We rated the maternity and gynaecology services as requiring improvement in all areas apart from caring which was rated as good.

Improvements were required to ensure that patients were protected from avoidable harm. We found that investigations of incidents were often delayed due to the reliance on clinical staff to complete initial investigations. There was no time allocated away from their clinical duties to undertake this investigation and only a small number of staff were trained to do this. Both nursing and medical staffing levels were lower than expected. The maternity service provided a real time ratio of one whole time equivalent midwife to 34 births, which was significantly below the national standard, due to sickness and absence. Consultant obstetric cover in the delivery suite was 60 hours a week which was significantly less than (worse) The Royal College of Obstetrics and Gynaecology (RCOG) guidance of 198 hours a week for a unit of this size. We found that emergency drugs were not stored securely and were therefore at risk of theft or tampering.

Improvements were required to ensure the effectiveness of the service. We found that appraisal rates for maternity and gynaecology nursing, midwifery, support and clerical staff were low at 51.7% overall. However, 93% of medical staff had received an appraisal. Community midwives did not have access to individual information technology. The obstetric assessment unit was operating without ratified guidelines, with minimum staff and in a location which caused disturbance to other patients and was remote from the women who were waiting to be treated. However we found that the normal birth, overall caesarean section and instrumental delivery rates were all better than the national average.

Women were very positive about the care they received and felt they were supported to make informed choices.

The service was not responsive as the elective gynaecology surgery backlog was 303 (53%) of the total patients waiting for admission. The 18 week to admission target had not been achieved; 440 patients that had waited over 18 weeks. The total number of

patients waiting for a first appointment was over the expected number for this service, with 30 patients waiting over 18 weeks. However, gynaecology cancer waiting time for 2015 had been achieved in all months except August. There were 21 closures of the Maternity Unit between October 2014 and September 2015.

Leadership within the service required improvement as the vision of the maternity service was not known by staff of any grade and not visible or embedded in practice. There was not enough investment in the divisional governance team in terms of training and sufficient numbers of staff to ensure timely investigation of incidents and cascading of any resulting learning points to clinical teams. There was a lack of succession planning and some staff were performing conflicting roles.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement



We rated maternity and gynaecology services as requires improvement for safety because:

- Investigation of incidents were often delayed due to the reliance on clinical staff to complete initial investigations with no time allocated away from their clinical duties, and the small number of staff trained to complete RCAs
- The department was not using the most recent serious incident framework guidance to categorise incidents. This meant that there was a risk that serious clinical incidents were not always being reported and investigated in line with national standards.
- The antenatal clinic waiting room was very small, with partners often being asked by staff to stand up and wait to enable pregnant women to sit down.
- Mandatory training across the maternity and gynaecology service was 76% compliant against a trust target of 85%.
- The maternity service provided a real time ratio of one whole time equivalent midwife to 34 births, which was significantly below the national standard.
- Consultant obstetric cover in the delivery suite was 60 hours a week which was significantly less than (worse) The Royal College of Obstetrics and Gynaecology (RCOG) guidance of 198 hours a week for a unit of this size.
- Emergency drugs were not stored securely therefore at risk of theft or tampering
- Cley ward (maternity and gynaecology) often received patients from other specialities which meant that staff were caring for patients with a greater needs than the staffing levels were set for. These patients could be admitted directly from emergency medical assessment areas with no senior review from the medical team, meaning their suitability for care on a non-specialist ward was not assessed at a senior level.

However we also found that:

- Clinical areas were clean and there were ample hand gel dispensers with instructions on how to cleanse hands. Staff followed good hand hygiene and were compliant to 'bare below the elbow' practices.
- The service was able to demonstrate how they met the requirements of the Abortion Act 1967 and associated guidelines through the recording of care.

Incidents

- The trust reported four serious incidents between August 2014 and July 2015. None of the serious incidents were further classified as never events. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- There was, however an incident of 'wrong site surgery' occurred in the Cromer minor surgery unit but which after review was not categorised as a never event. A root cause analysis (RCA) investigation was carried out which considered the contributory factors as to why the incident happened, lessons learned and how the incident should be categorised. The RCA recommended that the Department of Gynaecology should revisit its' protocols to prevent the possibility of wrong site surgery in the future.
- Monthly mortality and morbidity meetings were well attended by the multidisciplinary team (MDT) which meant that staff were able to describe changes in practice and lessons learned
- A standard template was used for RCAs investigations when patients suffered grade three or four pressure ulcers. Considering the trust's responsibilities in line with duty of candour regulations was not part of this template, therefore the obligation to discuss this with patients could be missed.
- Staff all confirmed that they could access the incident reporting system and knew the outcomes of any investigations or completed actions required.
- Investigation of incidents were often delayed due to the reliance on clinical staff to complete initial investigations with no time allocated away from their clinical duties, and the small number of staff trained to complete RCAs.
- All RCAs were completed by the risk midwife during office hours. This meant there was no process in place to conduct initial 24 and 72 hour investigations into serious incidents to identify any immediate learning.

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- The department was not using the serious incident framework produced by the National Patient Safety Agency (NPSA March 2015) and categorising incidents using less current guidance produced by the Centre for Maternal and Child Enquiries (CMACE, 2011). This meant that there was a risk that serious clinical incidents were not always being reported and investigated in line with national standards.
- In the gynaecology service, serious incidents, along with all incidents had been reported on the incident reporting system, were reviewed weekly by the multi-disciplinary team (MDT) to identify themes and trends.
- There were multiple routes for feedback of lessons learned to staff, for example: ward posters, staff risk update newsletter, ward meetings and the 'safe hands' meetings where staff discussed clinical care from the previous day.

Duty of Candour

- We spoke with five staff who described the duty of candour regulation, which is a new law in place from November 2014 requiring all NHS staff to be open and honest with patients when things go wrong. The trust had a patient information leaflet for duty of candour and being open. It was the responsibility of the final reviewer of all incident forms to ensure that duty of candour obligations had been met before the incident was closed.

Safety thermometer

- The NHS patient safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and harm free care. This enables measurement of the proportion of patients that were kept 'harm free' from pressure ulcers, falls and urine infections (inpatients with a catheter) and venous thromboembolism.
- Safety thermometer and safer staffing information was displayed at the gynaecology ward entrance and in the sisters' office in the gynaecological outpatient department.
- The maternity services had engaged with the trust wide safety thermometer (where relevant), consistently providing 100% harm free care. The results were displayed in areas for women and public to see.
- The maternity safety thermometer was launched by the Royal College of Obstetricians and Gynaecologists

(RCOG) in October 2014. This is a system of reporting on harm free care. The recommended areas of harm which have occurred included; perineal and/or abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. Also included was an Apgar score of less than seven at five minutes, and admissions to neonatal units. (The Apgar score is an assessment of overall new-born well-being.) Although the service had trialled the maternity safety thermometer and planned to roll it out in the future, it was not in use at the time of inspection.

Cleanliness, infection control and hygiene

- Clinical areas were visibly clean and there were ample hand gel dispensers with instructions on how to cleanse hands. Staff followed good hand hygiene and 'bare below the elbow' practices.
- However during the inspection the clinic area near the early pregnancy assessment unit had no hand gel in the dispenser on three consecutive days. This was escalated to senior staff however the hand gel was not replenished.
- Completed cleaning schedules and 'I am clean' stickers provided evidence of regular daily cleaning and equipment checks.
- Monthly infection prevention and control information was on display on entrance boards to the wards. This indicated to visitors and staff how many days in the previous month the ward had been free from healthcare acquired infection e.g. methicillin resistant staphylococcus aureus (MRSA) and clostridium difficile. During the month of inspection, November 2015, every day had been free of these infections.
- Monthly infection prevention and control audits took place in all clinical areas. The results were submitted to the infection prevention and control team who would feedback results to staff and identify themes.
- The monthly audits included hand hygiene, standard precautions, care of peripheral vascular device insertion and continuing care, and patient equipment and environment.
- Hand hygiene audit results for the gynaecology service showed each month in 2015 achieved 100% compliance rates except for August 2015 when compliance was 90%. Blakeney postnatal ward also showed 100% compliance apart from July 2015 when it was 93%.
- All areas across this service had a named infection prevention and control link nurse.

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Environment and equipment

- The doors to gain entry to the ward areas were locked. Staff spoke with visitors and asked who they intended to visit, and then allowed them entry. During the inspection, inspectors were asked to present their identification badges by the majority of staff when gaining entry to the wards.
- All equipment reviewed had portable appliance tested (PAT) within appropriate dates. A PAT test is an examination of electrical appliances and equipment to ensure they are safe to use.
- Every delivery room had a baby resuscitaires and baby scales. Check lists for the scales indicated they had been checked daily; however the resuscitaires check lists had not been completed. There was a separate check list for the ward that indicated the baby resuscitaires had been checked, however a member of staff using the resuscitaires in the delivery would not be able to easily see if it was ready to use.
- Adult resuscitation equipment in the areas visited was checked daily. All items that were held in the trolley were checked against the required checklist and were present and within date
- Cardiotocograph (CTG) machines were available for women whose babies needed monitoring in labour, and these were clean and PAT tested.
- Epidural trollies were found to be clean and well stocked.
- There were emergency evacuation nets to evacuate a mother from the birth pool in case of an emergency. Training had been given to staff supporting women having a pool birth and emergency drills had taken place to embed into practice.
- The antenatal clinic waiting room was very small, with partners often being asked by staff to stand up and wait to enable pregnant women to sit down.
- Three out of the nine community midwifery teams were not provided with bases, therefore were reliant on meeting at the team manager's home for team and individual meetings.

Medicines

- Controlled drugs had been checked according to trust policy in all areas. Staff were able to refer to their medicines policy, the up to date British National Formulary (BNF) or ask for pharmacy support if necessary.

- Locked drug fridges were checked daily and the temperature was recorded. Actions had been taken when this temperature exceeded above the normal range required for drugs which were moved to another fridge until the original fridge had been repaired.
- Emergency drugs were stored in drawers on the resuscitation and epidural trolleys in the corridors of the postnatal ward and delivery suite. A drug for local anaesthesia was visible and unsecured in the delivery rooms. This meant that these medicines were at risk of theft or tampering.
- We reviewed six prescription charts on the postnatal ward. All charts had signed and dated prescriptions, allergies documented and were legible. Three out of the six did not have a venous thromboembolism (VTE) assessment completed. This meant that if a woman required VTE prophylactic medication, she would not have received it as her risk had not been assessed. This was escalated to the ward team immediately.

Records

- We reviewed 17 sets of maternity records. Handheld records were dated and signed and individualised care plans were documented and updated.
- Out of 15 gynaecology nursing care plans and patient records reviewed, all had been completed appropriately.
- In both the gynaecology and maternity service there were records that had signatures that were illegible and no staff grade was present. We were advised that all staff had name stamps that should be used to reduce this risk; however this did not appear to have been embedded in practice.
- Appropriate recording and documentation of termination of pregnancy was seen in four sets of patient records. The service was able to demonstrate how they met the requirements of the Abortion Act 1967 and associated guidelines through the recording of care. All notes were signed, dated and legible and clear records of discussions with the woman were recorded.
- Child health records, known as 'red books', were distributed to mothers for each newborn baby.

Safeguarding

- Safeguarding policies and procedures were up to date and incorporated relevant guidance and legislation. Staff showed us how these could be easily accessed via the intranet.

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- 94% of all midwives were trained in safeguarding children level 3, against a trust compliance target of 80%. In gynaecology 77% nurses were trained to level 2, however only 41% medical staff (maternity and gynaecology combined) were compliant at level 2
- The trust target of compliance for safeguarding adults training was 80%. This was achieved by gynaecology nurses (97%) and medical staff (94%), however only 67% of midwives were reported to have completed this training.
- There was a named safeguarding link nurse for each area within gynaecology, and a specialist midwife for safeguarding.
- Specific safeguarding children paperwork for use within the maternity departments was implemented in November 2013. Satisfactory completion of this paperwork was audited in October 2014, with the main finding being the non-completion of discharge information. The audit was repeated in 2015 and demonstrated that discharge information was still not being completed to a satisfactory standard. There was no indication in the audit report how this continued non-compliance was going to be addressed or monitored
- There was no identified nurse or midwife for female genital mutilation, although there was a specialist midwife responsible for mental health, substance misuse and domestic violence.
- There were posters on the back of toilet doors informing patients of contact details if they were in an abusive relationship.

Mandatory training

- Mandatory training across the maternity and gynaecology service was 76%, against a trust November 2015 target of 85%. This was broken down across the staff groups as:
 - Additional clinical services 80%
 - Administrative and clerical 89%
 - Estates and ancillary 94%
 - Nursing and midwifery registered 74%
 - Medical and dental 69%
- Practice development nurses/midwives were employed by the service and they had the responsibility of facilitating all training and documenting compliance.

- Nursing staff felt they were supported to complete mandatory training and had individual staff files for both mandatory and non-mandatory training, documenting the courses they had undertaken and all competencies gained.
- The practice development midwife told us that mandatory training was documented in the training needs analysis; however, training needs could also be identified in action plans following audit or incident investigations and bespoke training was provided to address these.
- Barriers to staff being compliant in their mandatory training were named as lack of training rooms to run additional training sessions (although the maternity service had begun to provide training on a Saturday to address this) and staff being withdrawn from training sessions because of staff shortages.

Assessing and responding to patient risk

- The World Health Organisation (WHO) surgical checklist, five steps to safer surgery, was in place in gynaecology and maternity theatres. We examined the records of six women where safer surgery checklists were required and found they were completed.
- Staff were able to demonstrate the correct completion of the National Early Warning System and describe actions they would take to care for a deteriorating patient. 15 gynaecology patients' records were reviewed and all were complete and demonstrated clear appropriate escalation and actions.
- There was a documented discharge pathway for women transferred from theatres back to the ward and a handover checklist was completed.
- Often non maternity and gynaecology patients were admitted directly to Cley ward from emergency medical assessment areas with no senior review from the medical team. This meant their suitability for admission and care on a non-specialist ward would not have been assessed at a senior level and therefore may not be appropriate. When these patients (known as outliers) were admitted to maternity beds, this meant that midwives were moved to support antenatal patients, or to the postnatal ward, as they are not registered to provide nursing care for non-midwifery patients. This left a reduced number of nursing staff to care for patients with a higher acuity or receiving end of life care.

Midwifery and nursing staffing

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- The maternity department used BirthRate Plus methodology to calculate midwifery staffing levels, in combination with National Institute for Health and Care Excellence (NICE) Safe Midwifery Staffing, 2014.
- Royal College of Midwives (RCM, 2010) guidance, based on the expected national birth rate, was one whole time equivalent (WTE) midwife to 29.5 births.
- The ratio of all midwifery staff to births at the trust was 1:30 in May 2015, however the trust reported in October 2015 this had worsened to 1:32. There was further clarification that when sickness and maternity leave was taken into account, the service was actually running with one whole time equivalent midwife to 34 births, which was significantly below the national standard. This meant that midwives were less likely to be able to provide one to one care to women in labour (92% in August 2015, compared to 94.5% in February 2015). It also meant women were less likely to be assessed in triage within 30 minutes, and band seven ward managers were not able to complete essential non-clinical duties. E.g. review clinical incidents, as all of their time were spent providing care and maintaining clinical safety.
- Inadequate midwifery staffing levels and the midwifery to birth ratio of 1:34 were documented on the departmental risk register.
- Sickness rates for Midwives 2014-15 was 5.77% which was higher (worse than) the trust target of 3.5%.
- There was a business case, due to go to trust board in the week following our inspection, requesting funding for additional midwives, including specialist midwives in order to improve safe care to women.
- Expected levels and actual levels of staffing were displayed on notice boards in all ward areas.
- All women were provided with a named midwife.

Medical staffing

- Consultant obstetric cover in the delivery suite was 60 hours a week. This meant a consultant was present on the delivery suite from 8am to 7pm, Monday to Friday and 8.30am to 11.30am on a Saturday and 8.30am to 10.30am on a Sunday.
- The Royal College of Obstetrics and gynaecology guidelines (2007) state that a unit which has more than 5000 births a year (The trust had 5,853 births in 2015) required 98 hours of consultant presence by 2007, rising to 198 hours in 2010. Therefore the 60 hours consultant presence did not meet this standard.

- The insufficient number of consultants to meet recommended consultant cover requirements was documented on the departmental risk register.
- There was a business case due to go to trust board in the week following our inspection, requesting funding for an additional 38 hours of consultant presence on delivery suite. This business case was made in order to improve experienced decision making, supervision of trainees, safer high risk procedures and more efficient triage assessment.
- Although the proportion of consultants was similar to the national average, there was higher proportion of junior doctors (17% against a national average of 7%) and consequently a lower proportion of registrars (34% to a national average of 50%)

Major incident awareness and training

- The major incident policy was accessible to all staff on the intranet however knowledge of it was variable.
- No staff in either maternity or gynaecology could remember taking part in a practice drill in the last five years. They also confirmed there had been no recent training or table top exercises. This meant that in the event of a major incident, staff may not be aware of their responsibilities in line with the major incident policy.
- Staff had access to the business continuity plans via the intranet.

Are maternity and gynaecology services effective?

Requires improvement



Maternity and gynaecology services required improvement to be effective because:

- Appraisal rates for maternity and gynaecology nursing, midwifery, support and clerical staff were low at 52% overall.
- Community midwives did not have access to individual IT meaning they did not have remote access to current clinical guidelines leading to potential variations in care. There could also be a delay in information sharing that could affect patient outcomes,
- Guidelines and policies were not all based on guidance issued by professional and expert bodies

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- The service only met or exceeded one out of five of the indicators for the National Neonatal Audit Programme (NNAP) 2013

However we also found that:

- The normal birth, overall caesarean section and instrumental delivery rates were all better than the national average.
- 93 % of medical staff had received an appraisal
- There was an anaesthetic consultant on-call for the maternity service 24 hours a day, 7 days a week providing epidurals when requested

Evidence-based care and treatment

- Guidelines and policies were not all based on guidance issued by professional and expert bodies such as the National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetrics and Gynaecology (RCOG) safer childbirth guidelines. This meant we could not be sure that women were receiving care that was evidence based care, and could lead to some inconsistencies in practice. For example the service was non-compliant with NICE guidance for ectopic pregnancy and miscarriage, as it did not provide an early pregnancy assessment unit (EPAU) seven days a week as recommended. The impact of this is there could be a delay in treatment or misdiagnosis. This risk was cited on the divisional risk register, with a plan to work towards 7 day working in EPAU. The service was also non-compliant with NICE guidance (February 2015) for the management of gestational diabetes mellitus (GDM). The senior team were reviewing how to manage the impact of increased numbers of women being diagnosed with GDM and how increased interventions and care would impact on staffing. This was not on the divisional risk register.
- Staff had access to guidance, policies and procedures via the trust intranet.
- At the time of inspection the clinical guideline for the management of the obstetric assessment unit (OAU) was still in draft and had not been ratified by the clinical standards group and effectiveness sub-board, however was being used to provide care. This means there was a risk that women were receiving care that was not evidence based or in line with national guidance.
- Termination of pregnancy was delivered in line with the Abortion Act 1967 and supporting guidance.
- There was a rolling audit programme that showed outcomes of audits completed, recommendations and progress of any agreed actions. Local audits completed monthly included clinical safety, safer staffing and quality assurance and results were displayed for all patients and visitors to see.
- Monthly audit meetings were held and learning from audits was shared with staff at MDT governance meetings.
- The service only met or exceeded one out of five of the indicators for the National Neonatal Audit Programme (NNAP) 2013. The one that was met or exceeded related to 63% of babies receiving mother's milk on discharge from a neonatal unit against a national average of 58%.
- The service did not meet the standards in the NNAP audit 2013 for indicators relating to babies receiving retinopathy of prematurity screening (to screen for a visual impairment) (96% against a standard of 100%) and mothers receiving antenatal steroids (84% against a standard of 85%). It also did not meet the standard for documented consultation with parents and a senior member of neonatal team within 24 hours of admission (96% against a standard of 100%) and babies having their temperature taken within the first hour of birth (84% compared to a standard of 98% or above). The service had not produced an action plan as the results had only been published the week prior to inspection.
- The government had commissioned an independent investigation into maternity and neonatal services at Morecambe Bay NHS Trust to examine concerns raised by the occurrence of serious incidents. The report of its findings was published in May 2015, and included recommendations directed nationally at the NHS, to minimise the chance that these events would be repeated elsewhere. The service had completed a full review against the Morecambe Bay investigation report, benchmarking themselves as fully compliant for 15 of the recommendations, partially compliant for four. An action plan to ensure full compliance with all the recommendations had been completed.
- It was identified in the Failsafe Audit Report for Antenatal & Newborn Screening Programmes that the trust was unable to accurately identify their newborn eligible population and maternity has no robust process to ensure all babies for whom they are responsible are offered the newborn screening tests.

Pain relief

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- There was a dedicated anaesthetic consultant on-call for the maternity service 24 hours a day, seven days a week. This meant if women requested epidural anaesthesia it was available to them at all times.
- Women said that they were able to access pain relief in labour and after they had had their babies, and this was provided to them in a timely way.

Nutrition and hydration

- The maternity service had been assessed in the week before our inspection and achieved UNICEF Baby Friendly stage two accreditation. The Baby Friendly initiative is a worldwide programme of the World Health Organisation and UNICEF to promote breast feeding.
- Patients all had access to drinking water beside their bed unless they were nil by mouth.
- A choice of meals was available and patients completed menu choices for the day. Outside of meal times patients were offered toast. Feedback about the quality of meals from patients we talked to was mixed.
- There was multi-disciplinary team (MDT) support to ensure nutrition and hydration were assessed and managed effectively from a dietician and pharmacist.
- The Malnutrition Universal Scoring Tool (MUST) was seen to be used to assess and record patients' nutrition and hydration status correctly in six gynaecology patient records that were reviewed.
- There was no protected mealtime within Cley ward.

Patient outcomes

- The service maintained a maternity dashboard which reported on the clinical outcome indicators including those recommended by the Royal College of Obstetrics and Gynaecology (RCOG). This document was displayed for staff to see.
- The maternity service was not indicated as an outlier (performed significantly worse than national average) for maternal readmissions, neonatal readmissions or severe maternal infections diagnosed within six weeks of birth.
- There were 5,825 babies born under the care of the service in 2014, of which 63% were normal births which was higher (better) than the normal birth rate in England of 60%, and the trust target of 62.7%.
- The elective caesarean section rate was 11% higher (worse) than the national average, however the

emergency caesarean section rate was 12%, lower (better) than the national average. Overall the caesarean section rate in 2014 was lower (better) than the trust target and national average at 23% compared to 25%.

- The home birth rate for babies born between April to October 2015 was 1.8% below (worse) than the national average of 2.3% and a trust target of 2%. Staff told us they had seen a decline in home births since the opening of the midwife-led birthing unit in 2011.
- Between April to October 2015, the induction rate was 27%, which was higher (worse) than the trust target of 26.4% and the national average of 25%.
- The instrumental delivery rate between April to October 2015 was 12.3%, within the trust target of 10-13.8% and lower (better) than the national average of 12.9%. The rate of 3rd degree tears was 3.2%, lower (better) than the trust target of 3.5%, and there had been six 4th degree tears during this period, meeting the trust target of no more than one a month.
- We reviewed the notes of four women who had a termination of pregnancy and found all aspects of care provided met the required guidelines and legislation.
- The trust's leave policy for medical staff meant that requests needed to be made six weeks ahead of clinic bookings to avoid clinic cancellations. We were informed that this policy was often not adhered to and that clinics were often cancelled due to late leave requests
- There were 3,202 gynaecology outpatients clinics from 1 December 2014 to 30 November 2015, of which 594 (18%) clinics were cancelled.

Competent staff

- A preceptorship programme was provided for all newly qualified midwives, which had to be completed before progressing to a higher grade.
- Appraisal rates were low for nursing and midwifery staff at 47% completed and administrative and clerical staff at 54%.
- 93% of Medical staff had completed an appraisal in 2015
- Supervisors of midwives (SoMs) help midwives provide safe care and were accountable to the local supervising authority midwifery officer (LSAMO). The national recommendation for a SoM is to have a caseload of 15 midwives (1:15). There were less SoMs than the national recommendation with 20 midwives each to supervise (1:20). . This meant there were less SoMs than national

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guidelines recommended, with less time to complete the role. This risk was cited on the divisional risk register, and there was a plan to work with the local supervising authority to engage external SoMs to support existing supervisors in their role.

- Staff told us that they were supported to gain additional qualifications and to maintain their professional development.

Multidisciplinary working

- A review of two sets of mother and baby notes for families that required complex care demonstrated that multidisciplinary team working was effective. Antenatal services, community midwives, health visitors, the neonatal unit, GPs and social services staff all worked together with women and their families to plan the women's care throughout the pregnancy and after birth.
- The antenatal screening and fetal medicine team had good working relationships with specialist referral units and the local hospice.
- Parents were also supported by a Bliss nurse who worked for the UK baby charity set up to support babies born too soon, too small or too sick in the UK have the best possible chance of survival of reaching their full potential.
- Care and treatment plans were clearly documented and communicated effectively to other healthcare professionals e.g. GPs.

Seven-day services

- The early pregnancy assessment unit (EPAU) was open Monday to Saturday, with plans and funding obtained for it to be open seven days a week in the future.
- The physiotherapy and occupational services department supported patients Monday to Friday with a reduced service at weekends.
- A consultant obstetrician was present on the delivery suite from 8am to 7pm, Monday to Friday and 8.30am to 11.30am on a Saturday and 8.30am-10.30am on a Sunday.
- There was an anaesthetic consultant on-call for the maternity service 24 hours a day, seven days a week providing epidurals when requested.
- Community midwives provided an on call service to facilitate home births.

Access to information

- The service had a paper based notes system, with all care documented in individual hospital notes, and for pregnant women, hand held notes which they carried with them.
- Records were readily available to staff to refer to during the time of a woman's admission. Although, we saw three cases where patient notes were not available in the gynaecology outpatients department.
- GPs were able to make direct referrals to the gynaecology service.
- Staff were able to access test results and trust policies and procedures via the trust intranet system.
- Community midwives did not have access to individual IT apart from a basic mobile phone. This meant they did not have remote access to current clinical guidelines leading to the risk of potential variations in care. The further impact of this on care was there could also be a delay in information sharing that could affect patient outcomes e.g. delay in timely referrals and midwives did not have access to emails containing local or trust wide information. This was recorded on the departmental risk register as a risk and funding for a community IT system was outlined in the business case which was going to trust board in the week after our inspection.
- Of the six out of the nine community midwifery teams that had bases to work out of, only two had access to IT within the base.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent to care and treatment was obtained in line with national legislation and guidance, including the Mental Capacity Act.
- Mandatory safeguarding adults training included training on consent, the Mental Capacity Act, Deprivation of Liberty Safeguards and caring for patients with a learning disability. 97% of gynaecology nurses and 94% of medical staff were compliant with this training, however only 67% of midwives were reported to be compliant.
- Women who were being admitted for an elective caesarean section were given an easy to read consent form detailing all the potential risks of surgery to take home from the pre-operative clinic. This meant they could properly read the form and discuss it with family and note down any questions before they returned it (unsigned) to discuss with their consultant on the day of their surgery.

Maternity and gynaecology

Are maternity and gynaecology services caring?

Good



We rated maternity and gynaecology as good for caring because:

- Women were very positive about the care they received and felt they were supported to make informed choices. All the women we spoke with told us that they had been treated with kindness, dignity and respect. We saw good interactions between staff, women and their relatives.
- The percentage of women who would recommend friends and family to give birth at this hospital and would recommend its' postnatal services was consistently above the England average between July 2014 and June 2015
- A specialist, midwife-led 'birth reflections' clinic was provided to support women who wanted to come to terms with their birth experiences.

Compassionate care

- Between July 2014 and June 2015, the percentage of patients recommending the antenatal and postnatal community services ranged from 93% to 100%, with 100% being achieved the each month between January 2015 and May 2015.
- The percentage of women who would recommend friends and family to give birth at this hospital was consistently above the England average between July 2014 and June 2015.
- The percentage of women who would recommend the postnatal services in this hospital was consistently above the England average between July and June 2015.
- The service performed in line with other trusts for 13 of the 17 questions in the 2013 CQC survey of women's experiences of maternity services. Four outcomes that were better than other trusts were: staff introducing themselves, women feeling their concerns were taken seriously, women being involved in decisions about care and treatment with respect and dignity, and being treated with respect and dignity during labour and birth.

- Women were very positive about the care they received. All the women we spoke with told us that they had been treated with kindness, dignity and respect. There were good interactions between staff, women and their relatives.
- In a survey conducted by the local maternity services liaison committee, out of 36 women questioned 50% said they were satisfied with the overall care they received, and 39% said they were very satisfied.

Understanding and involvement of patients and those close to them

- Women were supported to make informed choices and told us that communication was good and they were involved with their care. We heard staff explain the details of their care plans to keep the women well informed.
- Women told us of their birth experiences and described staff as 'fantastic' and that they were patient and explained everything to them.

Emotional support

- The hospital chaplain described the excellent support and individualised care a woman received following a miscarriage.
- Birthing partners were encouraged to stay with women on the postnatal ward to provide extra support and enable early bonding for the family unit. There was a leaflet which was given to the partners giving advice on expectations of behaviour when staying on the ward.
- A patient told us that their partner was encouraged to stay over on the gynaecological ward when staff recognised that she needed that support.
- A specialist, midwife-led 'birth reflections' clinic was provided to support women who wanted to come to terms with their birth experiences.

Are maternity and gynaecology services responsive?

Requires improvement



We rated maternity and gynaecology services as requiring improvement to be responsive because:

Maternity and gynaecology

- The obstetric assessment unit had been operating without ratified guidelines, with minimum staff and in a location which caused disturbance to other patients and was remote from the women who were waiting to be treated.
- There were 21 closures of the maternity unit between October 2014 and September 2015. This meant that the hospital was closed to new admissions and women in labour needed to be diverted to other local hospitals.
- The gynaecology cancer waiting times target of 31 days to first treatment had an operational standard of 96%, achieved by the trust for six months with the exception of 87% for August 2015.
- The 18 week to admission target had not been achieved, with 17.5 % of patients that had waited over 18 weeks.
- 18 % of gynaecology clinics were cancelled out during the period of 1 December 2014 to 30 November 2015.
- There was no teenage pregnancy midwife or bereavement midwife meaning that vulnerable women with complex needs may not get specialist care and support.
- Partners were encouraged to stay over on the antenatal ward to support women undergoing induction or early labour, and on the postnatal ward to enable early bonding. Reclining chairs were provided for them for their comfort.
- The trust performed 'about the same' as other trusts when women were questioned about staff and care during labour, birth and after birth (CQC Maternity Care Survey, 2015)
- In the month before our inspection, an obstetric assessment unit (OAU) was created on Cley ward in order to provide a single point of entry to maternity services. The staff in the OAU saw women referred directly by themselves, community midwives, general practitioners, A&E, walk in centres or ambulance personnel and who needed prompt assessment of their pregnancy.
- The OAU was run by a midwife from delivery suite establishment, however as well as caring for women attending the OAU they were also required to answer the telephone, and request patient's notes. There was some support from the midwife running the pregnancy and wellbeing suite (PAWS), although clinical constraints meant that support was not always available.
- The location of the OAU also created challenges as it was situated between the gynaecology and antenatal in-patient areas of Cley ward. There was no space for a waiting room, so women waited to be seen in the delivery suite waiting room which was some distance away. Women could be in this waiting area for several hours with little communication from clinical staff.
- The location of the OAU also affected gynaecology patients on Cley ward, some receiving end of life care, as it increased the footfall through the ward, along with noise disturbance of additional patients and the telephone ringing.

However we also found that:

- The gynaecology cancer waiting time for 2015 had been achieved except for August.
- Every woman admitted for a termination of pregnancy was allocated a single room and admitted directly on the gynaecology ward.
- Partners were encouraged to stay over on the antenatal ward and on the postnatal ward. Reclining chairs were provided for them for their comfort.

Service planning and delivery to meet the needs of local people

- Women were given informed choice about where to give birth depending on clinical need. The community midwives offered an on-call service to support mothers who planned to have a home birth.
- The midwife-led birth unit (MLBU) was a 'home from home' environment designed to facilitate normal birth. From April to October 2015, approximately 17% of women delivered in the MLBU, with many of them making use of the birth pools for labour or delivery.
- Every woman admitted for a termination of pregnancy was allocated a single room and admitted directly on the gynaecology ward.

Access and flow

- The gynaecology cancer waiting times target of 31 days to first treatment had an operational standard of 96%, achieved by the trust for six months with the exception of 87% for August 2015.
- The senior team confirmed verbally during the inspection a 1200 backlog of patients waiting from first appointment after referral however data submitted post inspection identified that the total number of patients awaiting admission was 2514.

Maternity and gynaecology

- Of this 2514 backlog, 440 patients (17.5%) had waited over 18 weeks which had resulted in breaches for this target.
- In order to address the backlog the consultant team stated that surgery lists had been agreed for weekends once the additional modular theatres were open, but evidence submitted following this inspection confirmed that from 16 December 2015 on alternate Wednesdays a full day list was established.
- There were 21 closures of the maternity unit between October 2014 and September 2015. This meant that the hospital was closed to new admissions and women in labour needed to be diverted to other local hospitals.
- The reasons for the closures were: staffing alone four of 21, capacity (lack of birthing rooms) six of 21 and a combination of staffing and capacity, 11 out of 21. Senior leaders for the service told us that out of hours the band seven coordinator had the authority to close the unit, and this was not necessarily escalated to the consultant or executive manager on call. However the trust informed us that there was an established procedure where the decision is taken by a matron in conjunction with the executive on call. Although closures were monitored it was not trust policy to investigate each closure formally in order for lessons to be learned.
- Bed occupancy ranged between 60% and 68% between April 2013 and March 2015, which is above (worse than) the England average of between 55% and 60%. Bed occupancy had been seen to increase significantly since July 2014.
- 92% of women attended an antenatal appointment within 12 weeks six days of pregnancy, against (better than) a trust target of 90%.
- Senior staff told us the objective of the OAU was to improve flow and create capacity on delivery suite, as all women except those in obvious, active labour, were triaged in the OAU.
- There was no teenage pregnancy midwife or bereavement midwife meaning that vulnerable women with complex needs may not get continuity of care from a dedicated midwife able to provide specialist support and access to local support groups and networks. This had been recognised by the trust and an increase in specialist midwives formed part of the business case being presented to the trust board after our inspection.
- Link nurses and community midwives were identified to support patients with learning disabilities.
- All information on notice boards and leaflets were presented in English. Most staff didn't know what the most common second language was and how to get printed information in that language.
- The service used both interpreters and language line to communicate with women with whom English was not their first language.
- There was an excellent service performed by volunteers based within the gynaecology outpatient's area supporting carers and patients with learning difficulties. They treated all patients in a fair and respectful manner and ensured they were escorted to the clinic they required.

Learning from complaints and concerns

- Patient advice and liaison leaflets (PALS) containing information on how to raise a formal complaint, were available and were given when informal complaints were made. Patients and their families were advised if local resolution could not be reached to contact the PALS service to escalate their complaint formally.
- In response to complaints about personal information and confidentiality being not being protected, the self-booking station in the gynaecology outpatients department had been moved. This demonstrated that the trust listened to complaints and concerns from patients about their experiences and took action to improve care.
- 'You said we did' boards were displayed across the service for patients visitors to read what changes had been made in response to patient feedback.

Meeting people's individual needs

- Women who needed fetal medicine management were cared for by the hospitals fetal medicine department, however if they needed specialist input they were referred to another specialist centres.
- Specialist clinics were available which included a breech clinic, a vaginal birth after caesarean section clinic and a multiple pregnancy clinic.

Maternity and gynaecology

Are maternity and gynaecology services well-led?

Requires improvement



We rated that maternity and gynaecology services required improvement to be well-led because:

- The vision of the maternity service was not known by staff of any grade and not visible or embedded in practice.
- There was not enough investment in the divisional governance team in terms of training and sufficient numbers of staff to ensure timely investigation of incidents and cascading of any resulting learning points to clinical teams.
- There was a lack of succession planning and some staff were performing dual roles which the trust recognised as conflicting, for example the clinical director was also the governance lead.
- A lack of an IT infrastructure meant that community midwives were not being communicated with and did not receive service or trust wide information in a timely way.

However we also found that:

- The matron for gynaecology was described by staff as inspiring, supportive and approachable.
- The chair of the maternity services liaison committee (MSLC) felt the group had a 'real voice within the trust' and they were 'listened to and valued'.

Vision and strategy for this service

- The trust vision "to provide every patient with the care we want for those we love the most" was known by several of the staff we spoke to during the inspection.
- The trust wide strategy was described by senior staff with pride in their areas of responsibility.
- We were informed of the long term plan to ensure women's health patients were admitted to Cley ward and prevent outliers from other specialities occupying beds long term.
- Staff across the gynaecology service described that they "wanted the best for our patients".
- We reviewed the maternity strategy document which was written in July 2015, however had not been ratified by any board or committee. The vision for maternity

services was "to provide services that support the transition from pregnancy to family life with a safe, high quality service that is woman and family centred and that enables mothers and babies to achieve the best possible outcomes".

- During the inspection we asked staff working across the maternity service to tell us the vision of their service and no-one, including very senior leaders, was able to. The strategy was not displayed for staff to see. This demonstrates that the vision and strategy of the service was not embedded in practice.

Governance, risk management and quality measurement

- The trust had engaged in the East of England "sign up to safety" project, which is a national patient safety campaign.
- Risk registers were in use across the service and monitored monthly. Senior staff were aware of local risks and those identified as the top three.
- The service used a quality dashboard that was reviewed on a monthly basis which used the red, amber, green (RAG) flagging system to highlight areas of concern. These dashboards were seen displayed across the service.
- We attended the MDT gynaecology governance meeting, which was well attended. The agenda focused on risks and incidents and their management, and how lessons were learned and shared.
- Senior managers had completed a full review against the Morecambe Bay investigation report benchmarking themselves as fully compliant for 15 of the recommendations and partially compliant for four. An action plan to ensure full compliance with all the recommendations had been completed. Senior staff consistently reported there was not enough investment in the divisional governance team, meaning that investigations of incidents were often delayed due to the reliance of clinical staff reviewing incidents with no protected time.
- The governance lead told us there was a lack of service-wide training in RCA investigations, so they undertook all investigations into serious incidents. This meant that the cascading of immediate lessons learned and the timely completion of the RCA was reliant on their capacity to do this.

Leadership of service

Maternity and gynaecology

- Staff described local leadership and support as good. Managers were visible and approachable and there was effective communication within the service.
- The clinical director was also the governance lead, which the trust identified as a potential of conflict in terms of capacity to deliver on both roles and an absence of robust challenge.
- The matron for gynaecology was described by all staff we spoke with as inspiring, supportive and approachable. During our inspection she was observed to be credible, visible and we saw her nurturing, empowering and inspiring staff.
- The head of midwifery (HoM) was due to retire shortly after our inspection. The divisional directors shared with us their vision of responsibilities of her replacement; however this had not been discussed with the outgoing HoM or matrons in maternity. This lack of transparent succession planning was causing anxiety for the matrons and demonstrated a lack of communication and leadership. Concerns were raised by matrons around their lack of input in the decision of succession planning.
- The service had a very active maternity service liaison committee (MSLC) which is a forum for maternity service users, providers and commissioners of maternity services to group together to design services that meet the needs of local women, parents and their families.
- The chair of the MSLC felt the group had a 'real voice within the trust' and they were 'listened to and valued'. Senior managers of the service described the MSLC as having a positive and proactive influence on the care of women.
- Several staff in the maternity service had been nominated by patients for national awards.

Staff engagement

- A group of community midwifery leaders highlighted that the lack of community IT infrastructure meant that community midwifery teams were not being effectively communicated with and did not receive service or trust wide information in a timely way. This had been recognised by the senior team and the provision of an IT system in the community was the subject of a business case being presented to trust board after our inspection.
- Staff told us the trust took part in staff awards which are a way of recognising individuals and teams who go above and beyond the high standards expected by patients and colleagues.

Innovation, improvement and sustainability

- The senior team had prepared a business case to be presented at trust board the week after our inspection. The business case proposed increased midwifery staffing, increased obstetric cover, access to IT for community midwives and permanent development of an obstetric assessment unit. This demonstrated that senior teams were aware of all its risks to patient safety and was being pro- active in trying to find solutions to them.
- There was a new procedure room in the gynaecology outpatients department for women which meant they could undergo procedures in the department rather in general theatres.
- The division had a plan to reduce the surgical backlog by using the modular theatres and performing up to 21 operations every Saturday.
- The maternity department had won a bid to purchase hand held scanners, which would aid in confirming the presentation of babies of women in labour.

Culture within the service

- Not all staff were able to name the newly appointed chief executive, although they knew he had been substantially appointed.
- There was no mention of the bullying culture that was found on our unannounced inspection in May this year from any staff spoken to during the inspection.
- There was a culture of openness, flexibility and willingness among most teams and staff we met. Staff worked well together and positive working relationships existed between the multidisciplinary teams and other agencies.
- We observed conflict within the gynaecology consultant team over the prioritisation of cancer care. This had a negative impact on the communication between the benign and cancer care teams and increased a risk to continuity of care for patients.
- The trust also identified difficulties with the role of on-call consultant overnight as there was no resident consultant any night of the week. This meant the consultant on call was being disturbed frequently and this could potentially affect the consultant's ability to work safely the next day.

Public engagement

Services for children and young people

Safe	Requires improvement	
Effective	Good	
Caring	Good	
Responsive	Requires improvement	
Well-led	Requires improvement	
Overall	Requires improvement	

Information about the service

The Norfolk and Norwich University Hospitals NHS Foundation Trust provides services for children and young people, comprising of a tertiary level three neonatal unit and a children's department named the Jenny Lind Children's Hospital.

The neonatal unit has 42 cots inclusive of nine intensive care cots, six high dependency cots, 22 special care cots and five transitional care cots. Babies born between 23 weeks of pregnancy and 44 weeks of pregnancy are cared for in the unit, with the provision of neonatal surgery when required.

The Jenny Lind Children's Hospital comprises of the children's outpatients department; a children's assessment unit; a children's day ward; a children's ward named Buxton ward; and the provision of six beds on the day procedure unit named Lion ward. There is also the provision of four transition beds for adolescents aged 16 to 18 years on Cringleford ward. There are 10 clinic rooms in the children's outpatients department; eight beds, a clinic room and a treatment room on the children's assessment unit; four beds and a treatment room on the children's day ward; and 31 beds including four high dependency beds on Buxton ward.

The trust had 8,932 hospital admissions for children between January 2014 and December 2014, of which 74% were emergency admissions.

During the inspection, we visited the neonatal unit, the children's outpatients department, the children's assessment unit, the children's day ward, Buxton ward, the neonatal unit, Lion ward, and theatre recovery.

We spoke with 21 children and their parents or carers, 38 registered nursing staff, 10 support staff including health care assistants and nursery nurses, seven medical staff, three play therapists, two security staff, and seven administrative and managerial staff. We reviewed 26 sets of medical records and information requested by us and provided from the trust.

Services for children and young people

Summary of findings

The children and young people's service required improvement overall. We found that safety, responsiveness and leadership required improvement although the effectiveness and caring elements were found to be good.

Staff did not always follow processes to reduce the risk of infections spreading and to protect people from harmful waste. Security was not adequate in the children's day ward and Lion ward, where there was no secure entry and children could reach door handles. Resuscitation trolleys and equipment were not secure and emergency drugs were accessible on the top of trolleys. Resuscitation trolley checks were not consistent, according to the schedules set by the trust, and there was no grab bag of emergency equipment available to the crash team in all areas where children were treated. Controlled drugs, which are prescription medications that have their usage controlled as set out in United Kingdom law, were not checked consistently on Buxton ward. Compliance to safeguarding children training was not consistent for all staff working within the children and young people's service. There was no mental health nurse provision for mentally unwell children admitted to the service, and staff with mental health competencies were limited. Staff compliance rates for mandatory training, which helps staff to carry out their duties safely, were not achieved consistently. Staffing levels in nursing were consistently below the requirements of the service, due to high levels of maternity and sickness leave, meaning that patients may be at risk of not receiving appropriate care at the time they required it.

Incident management and the implementation of lessons learnt were established throughout the service. Most equipment checks were completed and documented. Records were completed clearly and consistently. There was a consistent use of an early warning scoring system for the detection of deteriorating children.

A robust audit programme was in place across the service with an associated learning and re-audit cycle

established. A practice development nurse supported nurses to obtain and maintain their competencies. There was a multidisciplinary approach in place across the whole service for the provision of care.

Readmission rates for children with long-term conditions were worse than the England average, meaning that care provided may not be adequate to keep conditions controlled.

Nurses were consistently caring towards patients and their families and children who regularly attended the service enjoyed spending time with the nursing staff. An independent survey of children and their parents or carers showed that the service performed well, in line with other trusts in the care it provided to children. There were established support groups for patients and their families that ensured support and guidance was available outside of the trust. Recreation facilities were available for children and adolescents while they used the service. Specialist nurses were available for children treated in different specialities, and their families, to give appropriate support and guidance.

Referral to treatment times did not always meet the 18-week standard that all patients have the right to expect. Children with complex needs did not always receive care that suited their needs in the best way. At time of peak capacity, children would be placed on adult wards where their needs may not be met.

Leaders did not always ensure that staff received adequate breaks. Staff respected the nurses in charge at a local level. The culture of the service was positive with staff willing to work extra hours to fill shortages. There was a robust clinical governance pathway from ward to Board level, where escalation of issues and risk management was managed and scrutinised.

Services for children and young people

Are services for children and young people safe?

Requires improvement



Children and young people's services were rated as required improvement for safe because;

- Infection prevention and control processes were not always followed to reduce the risk of spreading infections.
- The children's day ward and Lion ward did not provide adequate security to regulate entry and exit.
- Resuscitation equipment and emergency medicines were not secure and checks were inconsistent.
- Controlled drugs were not consistently checked each day on Buxton ward.
- Not all staff had the appropriate level of safeguarding children training.
- The benchmark set for mandatory training compliance was set for November 2015 at 85%, so although staff were compliant with this figure, many staff were not compliant with aspects of their mandatory training.
- Staff were not well equipped to respond to the deterioration of patients suffering from conditions affecting their mental health.
- Nursing staffing was consistently below the standards required to provide safe care, this meant that there was a reliance on bank and agency staff to improve staffing levels.

However:

- The management of incidents was robust and established amongst all staff. There was evidence of learning and communication to staff regarding outcomes of investigations.
- Equipment was calibrated and safety checked on a regular basis across all of the children and young people's service.
- Medicines were stored securely and nurses consistently performed a double sign-off of all medications administered.
- Patient records were up to date, clear, and well documented across the whole service.
- Although the benchmark for compliance to safeguarding children's training was low, staff were consistently achieving higher than this.

- Nurses used an early warning scoring system to assess if patients were deteriorating, and had clear escalation processes in place.

Incidents

- There had been no never events, which are serious and preventable patient safety incidents, or serious or moderate harm incidents reported to the national reporting and learning system from September 2014 to August 2015.
- Mortality and morbidity meetings took place monthly in the children and young people's service. Minutes of these meetings confirmed that individual cases were discussed to review the provision of care in each case, and identify potential learning. There were no trends in the mortality data. This meant that there were no recurrent reasons for deaths within the service.
- An embedded process for the reporting of, and learning from, incidents was in place within the children and young people's service. Nursing staff across the whole service were able to explain the process for reporting incidents and near misses, where an event has the potential to cause harm but avoids doing so. All incidents and near misses were recorded on to an electronic system that all staff had access to. Staff were informed of outcomes of incidents by receiving a summary and outcome email for each report they made. A quarterly risk newsletter, medications newsletter and ward based newsletters shared learning from incidents. Examples of learning included a sensor being fitted to a door to prevent the recurrence of fingers being trapped and improved labelling and storage of vaccines to prevent the wrong vaccine being given.

Duty of Candour

- All staff received training on the duty of candour on their induction to the trust. Duty of candour is a legal responsibility of care providers to inform patients and apologise when an error has occurred in their care causing moderate or significant harm. Existing staff received this training within mandatory governance update sessions. When the duty of candour had been actioned, this was recorded into the incident file on the electronic reporting system.

Cleanliness, infection control and hygiene

Services for children and young people

- Cohort nursing, where infectious patients are treated together in one area away from other patients, was practiced on Buxton ward. Four babies were isolated together in a closed bay that had signage outside informing staff to wear appropriate personal protective equipment (PPE), such as gloves and aprons.
- One adolescent recovering from surgery was also placed in this bay with no risk assessment. A clinical judgement had been made that there was no risk due to the distance that babies can cough not being far enough to infect the adolescent. A member of staff treating the adolescent did not wear Personal Protective Equipment (PPE), as that patient was not infectious. This meant that cohort nursing might not be effective in reducing the risk of infectious conditions spreading to other patients.
- Cytotoxic waste, which is waste of any kind from cytotoxic drug therapy such as chemotherapy, was not disposed of in accordance with trust policy. The trust policy stated that all contaminated waste should be placed in a heavy duty yellow bag with a pink label stating 'cytotoxic waste for incineration only' and that cytotoxic waste should be segregated from other clinical waste. On the children's day ward and Buxton ward, cytotoxic sharps were disposed of in segregation to other sharps, yet other cytotoxic waste, such as nappies, was disposed of with other clinical waste. The pink labels for this type of waste were only applied in the event of a cytotoxic waste spillage. This meant that staff did not adhere to the trust policy, and were not well protected from the hazardous effects of contact with cytotoxic waste. The handling of cytotoxic waste was not audited by the trust, meaning that non-compliance to the policy was not identified.
- There was no sluice on the children's day ward. A sluice is a room where human waste is disposed of, and reusable items such as bed linens are placed to be cleaned. Any clinical waste was carried to Buxton ward, approximately one minute's walk away. This meant that procedures such as the administration of enemas were not undertaken on the children's day ward due to the increased infection control risk.
- The changing of bed sheets was not consistent on Buxton ward, which increased the risk of infections developing from dirty linen. One parent explained that their child's bed sheets were changed immediately after a spillage; another parent said that their child's bed sheets had not been changed in two days despite the child bleeding onto the sheets. A parent had to change their child's bed sheets after the child had wet the bed, as the nurses were not available at that time.
- Auditing of hand hygiene and dress code was performed monthly in the children and young people's service. Between October 2014 and June 2015, compliance on Buxton ward, children's assessment unit and the children's day ward ranged between 95-100%. Compliance on the neonatal unit averaged at 100% for hand hygiene and 100% for dress code for the period April 2015 to July 2015. This meant that staff performed good hand hygiene and adhered to trust policy in relation to dress code.
- A daily cleaning rota was in place in the children's outpatients department covering all waiting areas, clinic rooms and toys. All areas were visibly clean.
- Cleaning of toys on Buxton ward was not consistent. Between July, August and September 2015 there were gaps of up to six days in the cleaning rota of the toys. The play assistants cleaned the toys although there was no clear individual responsibility for who was performing the task and when.
- A fortnightly environmental cleaning audit took place. Results were emailed to staff with associated actions to be taken. Actions were allocated to department, domestic and estates staff, and assessed for completion at the next audit. Progress of actions was evident at each fortnightly audit result.
- Cleaning of equipment took place frequently. Coloured 'I am clean' stickers were placed on equipment, such as drip stands, trolleys, and scales, across all of the children and young people's service, and included the date that the cleaning took place. This meant that equipment was less likely to be contaminated with harmful bacteria.
- Screening for and prevention of Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium Difficile (C. Difficile) was effective. There had been no incidents of hospital acquired MRSA between October 2014 and July 2015, which was the most recent data. There had been five cases of C. Difficile in the previous 12 months to this inspection.
- In the 2014 CQC children and young people's survey, the trust scored 9.0 out of 10 (in line with the England average) in the question of whether the hospital room or ward the child was seen in was considered clean.

Services for children and young people

Environment and equipment

- The children's day ward and Lion ward did not have appropriate security measures in place. There was no lock or intercom system in place, which meant that anyone could walk onto the wards. This had not been risk assessed. Door handles were within reach of children, which meant that children could let themselves out of the wards.
- Checks of the emergency resuscitation trolley was not consistent on the children's assessment unit and Buxton ward. Daily checks for the top of the trolleys were not always completed. Daily table top checks were reviewed for August, September, and October and up to 12 November 2015. There were 15 days where the table tops had not been checked throughout that period. Checks of the trolley drawers were not always completed every week. Between 7 September and 12 November 2015, the trolley drawers were checked every six to nine days. Defibrillators, an electronic device that applies an electric shock to restore a regular heart rhythm, were not always checked daily. In the week of 9 November to 13 November 2015, the defibrillators had been checked four days out of five. This meant that there was not robust assurance that emergency equipment was functional.
- Resuscitation trolleys were not secured on the children's assessment unit, Buxton ward and Lion ward. Emergency drugs were kept in a sealed plastic bag on top of the resuscitation trolleys. The drawers of the resuscitation trolleys were not locked and were sealed with paper 'I am clean' tape around each drawer. This meant that emergency equipment and drugs could be accessed by anyone.
- Resuscitation trolleys contained appropriate sized equipment for children.
- There were 52 children's outpatients clinics held outside of designated children's outpatient locations during the time of this inspection. Of these 52, the children's ears, nose and throat (ENT) and orthotics clinics were reviewed. Resuscitation equipment was shared with the adjacent head and neck OPD in the ENT clinic. Grab bags containing emergency resources for the paediatric crash team were available in the children and young people's service location but not in outpatients. This meant that there could be a delay in emergency equipment being available in the ENT clinic in the event of an emergency, which would affect patient safety.
- Adult nurses who were competent in the resuscitation of children provided care in the orthotic clinic. A children's resuscitation kit was available in the clinic along with a resuscitation trolley. This meant that staff could safely resuscitate children in this clinic, if required.
- The majority of equipment had been safety checked and calibrated. The electronics and medical engineering (EME) department completed calibration and safety checks. Seventeen pieces of equipment were checked in the children's outpatient department, with two of those pieces having no safety check or calibration dates. The oxygen and suction equipment were functional. The glucose monitor was quality control checked prior to every clinic. This happened three times a week. 27 pieces of equipment were sampled for safety and calibration checks in the children's assessment unit, all of which were within date. Three lots of oxygen and suction equipment were checked, all of which were functional. 16 pieces of equipment were checked in the children's day ward. One fridge was last safety checked in October 2013 and had no due date noted.
- Eight pieces of equipment were checked on the neonatal unit, all of which were within date of their last safety and calibration checks. The hospitals engineering department responded quickly to calls from the neonatal unit, and were available 8am to 5pm or by contacting switchboard out of hours on call. Spare monitors, ventilators, pumps and incubators were kept on the neonatal unit as a contingency in the event of equipment breakdown.
- In the 2014 CQC children and young people's survey, parents and carers of children under 16 years of age were asked to say whether the ward where their child stayed had appropriate equipment or adaptations for their child. The trust scored nine out of 10, which is in line with other trusts.

Medicines

- Medications were stored securely in the children and young people's service. Lockable cupboards and fridges were used on the children's day ward. Controlled drugs, which are prescription medications that have their usage controlled as set out in United Kingdom law, were kept in a locked room with one key holder providing access each shift on the children's assessment unit. Drugs and controlled drugs were checked daily and documented in a log book with two staff signatures on the children's assessment unit and the neonatal unit. All

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drugs were kept in locked cabinets on the neonatal unit. Permanent staff with key fobs accessed the drug room and controlled drugs were secured in a locked cupboard on Buxton ward.

- Controlled drugs were not consistently checked on Buxton ward. There had been six days in October 2015 where controlled drugs had not been checked. For 2015, controlled drugs were checked on average 27 days out of each month. A nurse in charge on Buxton ward audited controlled drug checks; however, the findings of these audits were not actioned.
- All medications were double-checked and signed for before administration on Buxton ward and the children's day ward, with the exception of paracetamol, ibuprofen and inhalers which staff could check singularly after they had achieved the appropriate competence. This was observed during the inspection and was recorded in patient records.

Records

- Patient records were not always stored securely on the children's day ward. Patient records were stored in an open cupboard next to a board that stated patient names of those admitted to the ward. This meant that anyone on the ward could identify and access patient records.
- Patient records were clear and easy to read across all of the children and young people's service. Different coloured stickers were used to identify the clinical notes of nurses, doctors, and multidisciplinary staff, such as physiotherapists and speech and language therapists. Records of 21 patients were reviewed and found to be consistently well documented with appropriate risk assessments completed.

Safeguarding

- The provision of safeguarding children was in the process of undergoing improvement. Planned changes were in their infancy, such as the revision of safeguarding training by the local safeguarding children board. A plan was in place to review the training requirement of safeguarding champions. There was a named nurse, deputy named nurse, deputy named midwife and a named doctor in the trust to lead and champion the safeguarding of children.
- Staff on Cringleford ward did not have level three safeguarding children training. This meant that staff

caring for adolescents in transition to adult services might not be aware of signs of abuse, or be able to make an appropriate referral in the case of a safeguarding concern.

- Safeguarding children supervision had been infrequent. The newly appointed safeguarding children lead nurse had set out a plan to roll out regular supervision for staff in the children's and young people's service. This plan was in the infancy of its roll out at the time of our inspection.
- The safeguarding children level three training module was provided to all the children and young people's service staff by a safeguarding children champion nurse. The nurse was trained to level three and had completed a train the trainer's course. This meant that the nurse could provide training up to their own level of competency.
- The benchmark of 75% for compliance with safeguarding children level three training was low. Staff were consistently over the benchmark rate for the past three months. For September 2015, Buxton ward nursing staff were 96% compliant; children's assessment unit, children's outpatients department and children's day ward nursing staff were 100% compliant; and neonatal nursing staff were 83% compliant. Medical staff across the neonatal unit and children's medicine and surgery averaged at 91% compliance.
- Mandatory training figures were reviewed from July to September 2015, for each month the children's clinical psychologist was not compliant with safeguarding children level three training. Bank staff were existing staff working extra hours and were therefore level three trained. Staff were educated about female genital mutilation within their training. A face-to-face refresher training session was delivered once every three years for level three.
- Safeguarding level two training for staff such as ward clerks was provided in an E-learning format.
- Weekly safeguarding audits were carried out with learning taking place. For example, poor paperwork was noted on Buxton ward. Changes were implemented to address this and subsequent audits showed the ward to be 100% compliant. A random check of 10 patient records from Buxton ward and children's assessment unit was performed throughout the inspection, which showed the safeguarding paperwork to be completed appropriately in all cases.

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- The children and young people's service had links in place with the local multiagency safeguarding hub (MASH). This enabled the service to refer safeguarding cases to the MASH for investigation in a prompt and accessible way. An example was given of prompt multiagency work between the community paediatrician, the forensic team and the trust where quick surgical action was taken within two hours of notification in a child sexual abuse case.
- In the children and young people's survey 2014, the trust performed in line with other trusts for questions relating to safeguarding and feeling safe in the hospital.

Mandatory training

- There was an overall threshold for training compliance set at 85% in November 2015. This threshold was a moving upward trajectory target.
- Mandatory training compliance was consistently better amongst nursing staff compared to medical staff in the children and young people's service. For July 2015 to September 2015, the average medical staff compliance rate was 14% lower than nursing staff for blood transfusion training; infection prevention and control and hand hygiene training; medicines management training; resuscitation of the neonate or new born training; and resuscitation of children training. This meant that we could not be assured that all staff were trained in all mandatory aspects to ensure patients received safe care and treatment.

Assessing and responding to patient risk

- Staff in the children and young people's service did not appropriately respond to risk in patients suffering from mental health problems. There were no known policies or processes in place for the management of acutely unwell mental health patients. Professional judgement was used in the decision to use security staff to ensure that patients did not abscond or pose a risk to themselves or others. The security staff received annual restraint and basic mental health training, which they felt was not sufficient for them to protect these children appropriately.
- Junior doctors felt supported by the senior medical staff in managing deteriorating babies on the neonatal unit. One example was given of a junior doctor contacting the out-of-hours consultant at night; the consultant offered to come in and support the junior doctor with that baby.

- The use of the early warning scoring (EWS) system was appropriate throughout the children and young people's service. Score levels were set so that it was clear when escalation needed to occur.
- Nurses used the situation background assessment recommendation (SBAR) method of communication to escalate concerns. This method ensured that critical information requiring urgent action was communicated effectively and safely.

Nursing staffing

- There were 28 whole time equivalent (WTE) unregistered nursing staff including healthcare assistants and assistant practitioners across the children and young people's service, and 148 whole time equivalent registered nursing staff including staff nurses, nurses in charge and advanced practitioners.
- Staffing was set according to acuity levels of patients using the guidance set by the Royal College of Nursing (RCN). This meant that the service aimed for staffing at a level and skill mix that was adequate for quality care provision, however, these levels were not always achieved due to vacancies, maternity leave and sickness.
- Registered nursing levels on Buxton ward were on average 11% below the required levels set by the RCN between August 2015 and October 2015. Unregistered nursing levels were on average 15% below the required levels. Registered nursing levels on the neonatal unit were on average 17% below the required standard between August 2015 and October 2015. Unregistered nursing levels were on average 3% below the required standard. There was no increase in incidents being reported, meaning that staff shortages were unlikely to have affected patient safety.
- Nursing staff WTE establishment for Buxton ward was 40.46, with an actual staffing level of 32.59 in July 2015. This meant that the ward was 7.87 WTE posts short for meeting the demand of the ward. WTE nursing establishment for the children's assessment unit was 18.24, with an actual staffing level of 13.73 in July 2015. This meant that the unit was 4.51 WTE posts short for the demand of the unit. WTE nursing establishment for the neonatal unit was 82.87, with an actual staffing level of 78.7 in July 2015. This meant that the unit was 4.17 WTE posts short for the demand of the unit. There was an on-going recruitment programme to address nursing shortages.

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- Nursing staffing on the neonatal unit did not always meet the British Association of Perinatal Medicine (BAPM) standard. The aim was to have 15 staff on each shift to cover 80% occupancy across intensive care, high dependency and special care. The unit was consistently had 13-14 staff rostered on each shift, and offered overtime to existing staff to cover the shortfall.
- The vacancy rate for both registered and unregistered nursing staff in September 2015 was 14% on children's assessment unit and the children's outpatient department; 13% for Buxton ward; and 12% for the neonatal ward.
- Consistent understaffing was noted on three months of nursing rotas on Buxton ward, requiring bank staff to cover the shortfall. Bank staff were regularly used in the children's outpatients department, children's assessment unit, neonatal unit and Buxton ward. Bank staff received an induction to the children's outpatients department including an explanation of processes and routines, and an induction to the children's assessment unit.
- The parents of a child in the high dependency unit on Buxton ward felt there was not enough staff for them to take a break away from their child, and that their child would not be safe if they were not present.
- Staffing on the children's day ward met the set establishment of two registered nursing staff per shift, which was 7am to 6pm, although this establishment did not enable staff to provide safe care. When both nurses were performing a clinical task in the treatment room or signing for medications, there was no other staff member to keep the other children on the day ward safe, as there was no healthcare assistant supporting the children's day ward.
- Existing staff working extra hours fulfilled any requirements for bank nursing on the neonatal unit. No agency staff were used on the neonatal unit.
- Advanced neonatal nurse practitioners (ANNP) were part of the junior doctor rota on the neonatal unit, providing 12.5 hours of cover during the day and 12.5 hours of cover at night. Staffing met the set establishment of four for November 2015 with an additional four trainee ANNPs in place.

Medical staffing

- There were 26 consultants for children and young people's services. This included five surgeons for the children and young people's service, seven on call

anaesthetists, and seven neonatal consultants. This number of consultant and registrar staff was slightly higher than the England average and met the needs of the service.

- Medical handover for neonatal care took place at 9am, 4:30pm, and 9pm on the neonatal unit. Children's medical care handover took place at 8:30am, 4:30pm and 9pm on the children's assessment unit. Children's and neonatal surgical care took place at 8am on the children's assessment unit and the neonatal unit respectively.
- There were three medical rotas in place to provide cover for children's medical care, children's surgical care and neonatal care. Children's medical care was staffed with nine WTE registrars, four trainee doctors, four trainee general practitioners and two foundation year doctors. Children's surgical care was staffed with six WTE registrars, two trainee doctors, three fellows, one staff grade doctor, one core trainee doctor and one rotating trainee doctor. Eight WTE specialist registrars, five trainee doctors, and a 0.5 WTE research doctor staffed the neonatal unit.
- There had been no medical staffing gaps in the neonatal unit for the past six months. There had been a gap of 0.5 WTE in July and August 2015 for children's medical and surgical care, existing staff worked extra hours to fill this gap for those two months.

Major incident awareness and training

- There was a trust-wide major incident response plan. This included specific plans for the care of children involved in a major incident.
- Two staff members for the children and young people's service, a senior nurse and a consultant, had received major incident training in September 2014. There was no record of any further training having taken place, which meant that we were not assured that staff were informed of what to do in the event of a major incident.

Are services for children and young people effective?

Good



Effectiveness was rated as good for the children and young people's service because:

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- There was a comprehensive audit programme in place with demonstrated implementation of learning from action points.
- The assessment of pain and the provision of analgesia were consistent across the whole service, and included the support of a multidisciplinary team.
- Nutrition and hydration records were consistent and mothers were supported to breastfeed by competent staff.
- A practice development nurse was proactive in ensuring that staff had the correct competencies for the requirements of the service, as well as for the revalidation of staff, and a comprehensive plan was in place to roll out further competency training.
- Wards, units and specialities within the service consistently used a multidisciplinary approach to care, ensuring that the needs of a patient were considered.
- A national audit of children's diabetes management showed that diabetes controlled at an acceptable level at this trust was better than the England average.

However

- Readmission rates for long-term conditions were above the England average for epilepsy and diabetes.
- Staff appraisal rates were very low, particularly on Buxton ward at 43%. This meant that effective evaluation of staff and development planning was not happening in a timely manner.

Evidence-based care and treatment

- The children and young people's service had a robust local audit programme that tracked audit registration including the rationale, methodology, results, associated action plans, improvements, and re-audit cycle. Audits included the use of children's early warning scores; drug protocol audits; audit against National Institute for Health and Care Excellence (NICE) guidance for feverish children; and audits of patient experience. Action plans were included in the clinical audit registration forms once the audits were completed. This included a due date and a date for re-audit to test the implementation of the action plans.
- There was implementation of the Academy of Medical Royal Colleges Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients. This

meant that individual named clinicians took accountability for a patient's care on each shift and that patients knew whom their responsible clinician and named nurse were.

- The neonatal unit participated in the BLISS (baby life support systems) baby charter, which is a scheme that ensures a family-centred approach in the care of sick and premature babies. The unit also participated in the Baby Friendly initiative by UNICEF, which improves the practice of infant feeding in health care settings, and had achieved stage three status. This meant that trained staff could support the experience of parents in feeding their babies.

Pain relief

- Four nurses were trained and competent in the use of a patient group direction (PGD) on Buxton ward. This meant children requiring urgent access to over-the-counter pain relief such as paracetamol and ibuprofen could receive these medications without the need for a doctor to attend and prescribe.
- There was a multidisciplinary approach to pain relief on Buxton ward. Nursing staff liaised with the medical staff for the provision of pain relief, and had ease of access to the anaesthetic staff for support. Children's medical and surgical staff responded quickly to nursing requests to attend. The practice development nurse attended the children's pain team meeting and was able to feedback learning to the nursing staff.
- There was a range of analgesia delivery methods, including epidural and patient controlled analgesia (PCA) when appropriate, on Buxton ward.
- Pain assessment tools were in use on Buxton ward according to the age of the child. A pictorial self-assessment tool was used that enabled children to choose the image that most represented the level of pain they felt. For younger children a face, legs, arms and consolability (FLAC) chart was used to assess levels of pain.
- There was a multidisciplinary approach to pain relief on the neonatal unit with medical staff available to prescribe medications, a specialist pharmacist in attendance on the unit five days a week and available on call out of hours. There was access to the children's anaesthetic team by the nursing staff.
- The assessment of pain and provision of pain relief was robust on the neonatal unit. Pain assessment was recorded hourly on all observation charts. Sucrose was

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used to comfort and distract babies during painful procedures. Consultants, registrars and advanced neonatal nurse practitioners could prescribe appropriate medication.

Nutrition and hydration

- Three breastfeeding link nurses supported the nutritional needs of breastfed babies and their mothers on Buxton ward.
- Care plans included a screening tool for the assessment of malnutrition in paediatrics (STAMP); this meant that children were assessed as part of their care plan for malnutrition upon admission and during their stay in hospital.
- The recording of nutrition and hydration input and output was included in care plans on the neonatal unit. Fluid charts were completed, and the provision of total parenteral nutrition was recorded in five sets of neonatal notes we reviewed.
- Patient and parent experience of the provision of nutrition and hydration was not consistently good. One parent said the catering team had prepared a blended diet for their child with additional needs. Another parent stated that they had been informed regarding the risk of feeding their child when they were nil-by-mouth. However, one parent and child had to wait two hours for food that did not compromise their allergies. Another parent said their child did not like the food on offer and had subsequently not eaten. One adolescent patient with an eating disorder had discussed and made an agreement to eat with the nursing staff, however the patient's meal was never prepared and they went without food for several hours.

Patient outcomes

- An audit was completed to check the management of asthma and wheeze against the NICE quality standard for asthma. The results showed national guidelines were not met in the areas of asthma diagnosis, documenting attack severity, assessing asthma control, the provision of personalised asthma action plans, reviewing asthmatic children prior to discharge, and annual follow up appointments. An action plan had been set with clear dates for completion and was being undertaken at the time of this inspection.
- Data from the 2014 national neonatal audit programme (NNAP) showed that the trust performed below the NNAP standard in two areas out of 10 audit measures.

Neonates had their temperatures checked within an hour of birth in 88% of cases, compared to the set standard of 98-100%. Parent consultations were documented within 24 hours of admission in 97% of cases compared to the standard of 100%. These results showed an improvement from the 2013 audit data. This data was published the week before this inspection and therefore any action plan was yet to be devised.

- Readmission rates for children with asthma were better than the England average; however, readmission rates for children with diabetes and epilepsy were worse than the England average. This meant that care provision for long-term conditions may not always be effective to keep those children stable at home. The trust's draft strategy for the service included developing services with specialist teams such as long-term conditions teams.
- Results from the 2013/14 paediatric diabetes audit showed a higher percentage of patients with glycated haemoglobin (HbA1c) under 7.5% than the national average, indicating that more children have diabetes controlled to an acceptable limit compared to the average for England. The median HbA1c level is similar to the national average. This represents an improvement on the previous year, both in terms of the median level and number of children with an HbA1c level under 7.5%. These results are not reflective of the high readmission rate for diabetic children. This indicates a gap in the effectiveness of care.

Competent staff

- Staff were not always appraised in a timely manner. Appraisal rates at the end of October 2015 were 43% for Buxton ward; 77% for the children's assessment unit; 75% for the children's day ward; 100% for the children's outpatient department; and 83% for the neonatal unit. Long-term sickness absence, an influx of new starters, and maternity leave absence had brought the rate of appraised staff down. These capacity issues meant staff were often being appraised outside of their working hours and away from the trust site. Staff yet to be appraised had a booked date for their appraisal.
- The practice development nurse was the dedicated revalidation champion in the children and young people's service. Senior nursing colleagues provided supervision to the revalidation champion. Revalidation

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is the process where nurses demonstrate that they practice in a safe way. The revalidation champion had set up a programme to take nurses through the revalidation process.

- The practice development nurse supported the development of staff competence. A preceptorship programme mapped against the 'six c's' of care, compassion, competence, communication, courage and commitment had been implemented. This included set study days and the development of 'episode of care' for newly qualified nurses. Intra-venous competencies were in the preceptorship package so that newly qualified staff received their training for this once they had been qualified for approximately six months. Epidural and patient controlled analgesia competencies were achieved at approximately one-year post qualification. Preceptors worked with the nurses and gave feedback on their competence. This ensured that new nurses were supported in becoming more competent in an appropriate period.
- The practice development nurse had developed a 'share your care' training evaluation scheme. This was based on the 'six c's'. This scheme assessed whether staff members had learnt from their training and gained the appropriate competence. This meant that the competence of nurses was under review to ensure they could provide the best care possible.
- Support was available for staff to develop knowledge, skills and competence in several areas. The breastfeeding link nurses on Buxton ward were supported in maintaining their UNICEF level three competence by the breastfeeding lead for the trust. The local university provided training for mental health conditions to staff, which one sister had attended with the aim of sending other nurses on by May 2016. The local child and adolescent mental health service (CAMHS) provided a joint course with a dietitian from the trust to educate nursing staff on eating disorders in children and young people.
- Nursing staff taking care of transition adolescents on Cringleford were adult nurses, who received a one-day training session on how to care for adolescents from specialist nurses. This meant that the nurses in charge of young people's transition to adult services had given the nurses on the ward support to care for these young people.
- There were 43 nursing staff on Buxton ward. Of those 43, 14 were trained in the provision of high dependency

care; 14 were trained in the provision of epidural and patient controlled analgesia; 19 were trained in the provision of intra-venous therapy; eight were trained in the provision of chemotherapy; eight were trained in the accessing of portacaths (devices placed under the skin for longer term access to veins); 14 were trained in European paediatric life support (EPLS); 21 were trained in the single sign off for the administration of medications; 14 were trained in tracheostomy care and received annual updates from the tracheostomy lead nurse; and 20 were trained mentors.

- A new plan was in the process of implementation, which aimed to provide clinical supervision once a year. This included issues for supervision being identified at appraisal then a plan made to address them. There was an open-door policy for nursing staff to access the sister throughout the year if a nurse felt a more urgent requirement for supervision. One example was of a nurse requiring supervision outside of their appraisal for the provision of blood transfusions. The nurse was set up with a supervisory plan to address this.
- Both children and adult nurses staffed the Lion day surgery ward. All adult nurses had completed competencies on caring for children.
- Specialist nurses supporting the long-term conditions services were visible and accessible to staff on Buxton ward. Specialist nurses supported the diabetes service; endocrinology service; oncology service; rheumatology service; gastroenterology service; respiratory service; orthopaedic service; weight management service; and the urology service. There were draft plans in the strategy to increase specialist support for the long-term conditions services.

Multidisciplinary working

- Working relationships with other providers of specialist care were established and effective. The trust referred children requiring intensive care, burns, nephrology and cardiology care to other trusts providing those specialist services. Specialists attended this trust to provide children's cardiology and nephrology outpatient clinics throughout the year. Another trust received referrals for babies on the neonatal unit requiring neurosurgery.
- The trust provided level two trauma orthopaedic services to children and young people and there was a shared level two oncology service with another trust. Children's surgical outreach programmes were provided to three other trusts in the region.

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- Specialist nurses and consultants worked in partnership to provide effective care across different specialisms. A range of services including cystic fibrosis, diabetes and rheumatology were consultant led. Specialist nurses supported the gastroenterology, urology, neurology and orthopaedic services. Specialist nurses ran the neonatal unit outreach service, the rapid response team for unexpected child deaths, the constipation service and the weight management service.
- The children's nutrition group provided support to the total parenteral nutrition (where nutrition is provided directly into a vein intravenously) service and a children's allergist provided support to the children's allergy service. A BLISS (baby life support systems) nurse supported the neonatal outreach service, including support with feeding, oxygen therapy, parent education and the facilitation of a peer support group for parents.
- There was a multidisciplinary approach to care on the neonatal unit. Ward rounds were consultant led with input from the named nurse looking after each baby. There was speech and language therapy input for feeding issues including cleft lip and palate and an ophthalmologist attended the unit on a weekly basis.
- The acute neonatal transport service provided support to babies requiring transfer to other trusts 24 hours a day, seven days a week.
- Specialist nurses for the clinical specialities led on the transition of an adolescent into adult care. A traffic light system was in place for the planned transition of children into adult's services. The system started with a 14-year-old adolescent's status as 'red' with the aim of their status being 'green' by the time they were 16. This meant that the adolescent had two years to understand and develop the skills required to become more independent with their own care. The traffic light system was recorded in the young person's medical records.
- A team of two trained play therapists and two assistant play therapists was based on Buxton ward. A play therapist attended Cringleford ward daily to spend time with the adolescents on the ward. A play therapist attended the children's assessment unit when required to assist with distraction of children undergoing investigations and procedures.
- There was a multidisciplinary approach to the provision of specialist services, with regular steering groups established. A transition steering group with a multidisciplinary membership met on a quarterly basis. A multidisciplinary cystic fibrosis steering group was in

place that had membership from the respiratory specialist nurse; adult and children's medical staff; and physiotherapy. The specialist nurse was able to discuss transition arrangements for adolescents using the respiratory service with the group. One parent and carer said their child received excellent multidisciplinary care for the treatment of all aspects of global developmental delay (GDD), and their grandchild received excellent multidisciplinary care for the treatment of their type one diabetes.

- The provision of mental health support to children was disjointed at the trust. Children with eating disorders, overdoses and suicide attempts were admitted to Buxton ward. Social services, the local multi-agency safeguarding hub, the emergency social workers and local school nurses were involved with the ward to support these patients. There was support provided by the local CAMHS to children on the ward, although two members of staff did not feel this support was effective. CAMHS called the ward every morning to assess current levels of need. There was an eating disorders team and a psychiatric liaison team for the ward to access for advice and crisis management; however, the accessibility of these teams was inconsistent. We observed one patient's care who had their mental health care planned for after they were discharged from the ward. This meant that whilst their medical care needs were met on the ward, their mental health needs were not.

Seven-day services

- Seven day provision of senior medical cover was in place. Out-of-hours cover for children's medical and surgical care was provided by two registrars up to midnight, then one registrar from midnight until the morning handover at 8:30am. Two middle grade doctors and one junior doctor provided weekend cover.
- There was 10.5 hours of consultant cover for medicine with an additional consultant providing cover to the children's assessment unit between 8:30am and 9pm. There was one on-call consultant for medicine from 7pm until the morning handover. There was 24-hour on-call consultant cover for surgery, inclusive of 11 hours onsite in the daytime and 13 hours offsite at night.
- Two consultants covered the neonatal unit from 8am to 10pm, with offsite cover between 10pm and 9am. Junior doctors provided cover alongside advanced neonatal nurse practitioners in a team of five, for 12.5 hours in the

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daytime and in a team of three for 12.5 hours at night. Out of hours cover on the neonatal unit was divided into support for babies requiring intensive care and babies requiring special care alongside support to babies on the postnatal ward.

- A business case was in the process of being approved for the neonatal outreach team, for the addition of two days of band six nursing so that the current existing five-day service could be extended to seven days.

Access to information

- There was an electronic system in use for the management of patients throughout the trust to record patient attendances, admissions, discharges and investigations. This meant staff could access information quickly from the nearest computer with secure log in details.
- A computer on wheels was used on the ward rounds so that discharge documentation and discharge medications could be arranged from the bedside. Discharge correspondence was posted to the general practitioner as well as being available on the ICE electronic system which enables clinicians in primary care to access information generated in secondary care. Alerts were set up on the trust electronic system for patients with long-term conditions. This meant that whenever a patient with a condition such as diabetes, cystic fibrosis or learning disabilities attended hospital, an alert would display on the system so that the appropriate specialist nurse could be informed.
- The use of the personal child health record, also known as the red book, was not actively encouraged in the children and young people's service. Height, weight, heel prick test results, and notes for the community health visitor were entered into the red books when parents and carers brought them into hospital with the child. This was dependent on the adult bringing their child's book to hospital. This meant that children's health and developmental progress might not be readily available to all professionals involved in their care.

Consent

- Staff understood Gillick competence, to assess whether a child has the appropriate understanding and maturity to consent to care. Competence was assessed primarily by age, if a child was aged 12 or over. If the child also demonstrated that they were of sound mind and that they were capable of making decisions about their care

then they were deemed to have the Gillick competence. One set of patient records was sampled on the Lion ward that showed discussion had occurred with the adolescent and their parents, and the patient had signed their own consent with their parent's approval. Consent for procedures was clearly and consistently recorded from parents of young children.

Are services for children and young people caring?

Good



Caring was rated as good in the children and young people's service because;

- An independent survey showed that children and their parents consistently scored the trust highly for being compassionate and providing support.
- Parents were regularly involved in their children's care.
- Nursing staff were compassionate and supportive to both patients and their parents or carers.
- Regular attenders felt comfortable and happy to be with the nurses.

However;

- Privacy was not well maintained on Lion ward, with no private area to discuss and obtain consent for procedures.

Compassionate care

- The Care Quality Commission children and young people's survey showed that the trust's performance was in line with other trusts across the whole survey. Specifically in regards to providing dignity to children; parents having confidence and trust in the staff; children receiving help when they needed it; looking after children well; supporting children when they were worried, being friendly to children and listening to children.
- Nursing care was personalised on the children's day ward. Regular attendees to the ward arrived excited to see their nurses and there was an understanding of each child's likes. One nurse provided a child with a toy that she had saved for them, knowing that they would like it.
- Parents felt their children were treated with compassion across the children and young people's service. One set

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of parents said that they felt their child was safe on the ward. Other parents said that nursing staff were lovely and tried to make their children laugh and another parent stated the nursing staff had calmed their child down when they had been anxious.

- A parent on the neonatal unit described staff as fantastic and said staff talked to their baby while providing care.
- Privacy and dignity was not well maintained on Lion ward. There was a lack of private areas for discussion. This meant staff had to discuss and obtain consent with children and their families in the play area among other patients. This was not identified on the risk register.

Understanding and involvement of patients and those close to them

- Understanding and involvement of parents was inconsistent and varied. One grandparent on the neonatal unit said the majority of staff were “awesome” but some nurses seemed less tolerant of young mothers. Another relative of a patient described some consultants as “magnificent” but that they felt like just a number to other consultant staff. One parent said that their child’s plan of care was made clear to them; they understood what was happening and were involved in every decision. Another parent was offered the opportunity to buy children’s meals on the ward so they could eat with their child.
- Parents were kept informed and were involved in decision making around the care of their babies on the neonatal unit. Three sets of patient records were sampled, all with parental discussions recorded.

Emotional support

- Spiritual support was available to all patients and their families from a chaplaincy service across the children’s ward and the neonatal unit. The chaplaincy service supported people from different faith backgrounds and those with no faith.
- Nursing staff were emotionally supportive to both parents and children. One parent on the neonatal unit said they received great emotional support from kind and genuine staff who understood their need as a parent and not just their baby’s needs.
- One adolescent patient said that the nursing staff were supportive throughout times of need during their admission.

Are services for children and young people responsive?

Requires improvement



Responsive was rated as required improvement in the children and young people’s service because;

- Referral to treatment time (RTT) was not met consistently across different specialisms such as orthopaedics and ears, nose and throat (ENT), meaning that children were not always treated within 18 weeks of referral.
- The trust’s escalation policy meant that adolescents were moved from Cringleford ward to Buxton ward in times of high capacity pressures. This meant that patient’s care and transition experience was disrupted.
- Feedback to parents or carers who complained was not consistent across the service.
- Children with complex needs did not always have their needs met and parents felt they had to be much more involved to ensure their children were safe and received appropriate care.

However;

- There were condition-specific groups set up for patients and their families to ensure support and guidance were available, such as the family forum for children with complex needs and the kangaroo group for families of neonates.
- Information booklets were available in the neonatal unit that informed parents of support groups they could access.
- Age appropriate recreation facilities were in place across the whole of the children and young people’s service.
- Collaboration took place between nursing and medical staff to ensure a smooth discharge process for patients.
- Staff across the whole service were aware of the complaints process and received feedback and learning.

Service planning and delivery to meet the needs of local people

- There were 438 admissions, between October 2014 and September 2015, of 14 to 17 year old patients to adult wards, excluding critical care, coronary care and maternity related admissions. These admissions were to a range of medical and surgical wards where nurses

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trained to deliver care to adults were providing care to children and young people. This meant that the specific needs of children and young people might not have been met.

- A family forum was set up for families of children with complex needs in the acute environment. This forum was led by nurses and had access to a complex needs steering group which shaped the service.
- Recreation facilities were age appropriate for the range of children using the children and young people's service. There were rooms for both children and adolescents on Buxton ward. The playroom had play equipment for younger children, and the adolescent room had facilities such as a game console, computer tablet, and board games for older children. The waiting area in the children's outpatients department had a range of toys, books and games to entertain children of all ages whilst they waited to be seen.
- Parents were supported through their baby's stay on the neonatal unit. A sibling's play area was on the unit and was accessible at all times for other children of parents of neonates. There was accommodation for parents to spend the night when their babies required intensive care for a weekly fee, as well as in preparation for taking their babies home. There was access to a family grant that provided a monthly allowance for parents with babies on the unit.
- A nurse-led neonatal outreach team worked in the community to facilitate early discharge. Parents and babies were supported with several issues such as naso-gastric tube feeding, home oxygen, and stoma care. Parents received training on naso-gastric tube feeding and had their competency checked to ensure they could provide this care safely. Babies supported by the neonatal outreach team were given open access, which is access to hospital care without having to go through the general practitioner (GP) or emergency department, to the children's assessment unit for out-of-hours emergency care.

Access and flow

- Patients have the right to be treated within 18 weeks of being referred for treatment (RTT). The children and young people's service did not consistently see patients within 18 weeks. A target of 90% was set for patients to receive inpatient treatment within 18 weeks. Data for October 2015 showed that this target was achieved in the specialities of surgery at 96%, and endocrinology,

rheumatology and interventional radiology all at 100%. However, this target was not achieved in the specialties of gastroenterology at 83%, trauma and orthopaedics at 82% and respiratory medicine at 77%.

- A target of 95% was set for patients to receive non-admitted treatment within 18 weeks. Data for October 2015 showed that this target was achieved in the specialties of surgery at 98%, trauma and orthopaedics at 96%, ophthalmology at 97%, haematology, dermatology, oncology, rheumatology, diabetic medicine all at 100%, and general paediatrics at 98%. However, this target was not achieved in the specialties of ears, nose and throat at 72%, plastic surgery at 92%, gastroenterology at 92%, endocrinology at 88%, respiratory medicine at 87%, and neurology at 91%.
- There were 18 surgical sessions held each month, inclusive of orthopaedics, ENT, plastics, maxillo-facial, ophthalmology and gastroenterology. There were also eight day procedures sessions each month. There was no evidence of any plans to increase the number of surgical sessions to improve the RTT.
- Theatre lists were scheduled so that adults and children were not treated at the same time.
- One parent stated their child had been given a date for surgery very quickly. Their child had been given a good explanation of what was going to happen and was given the opportunity to ask any questions.
- During times of high demand for inpatient beds, young people admitted to Cringleford ward were transferred to Buxton ward according to the trust's escalation policy. Patients received treatment as transitioning adolescents on Cringleford ward, but as children on Buxton ward. Staff confirmed that this had occurred several times, including at night without any patient consultation, there was no evidence of any incident reports in the data submitted to the Care Quality Commission and it was not on any risk register.
- Between May 2013 and June 2015, neonatal critical care bed occupancy was 100% in five months, four consecutive months between November 2013 and February 2014 and June 2015. In 2015, rates fluctuated just above the England average. Overall bed occupancy rates for July 2015 to September 2015 were 59% for Buxton ward, 34% for children's assessment unit and 65% for the neonatal unit. This meant that service demand had reduced consistently.

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- Admission to the children and young people's service in the 12 months leading up to the inspection was in line with national levels. There had been approximately 600-700 day admissions to the, 200-300 elective admissions, 1,500 emergency admissions, 800-850 neonatal admissions, 2,000 new outpatient appointments and 2,500 follow up outpatient appointments. There had been approximately 40-50 cases of neonatal surgeries.
- Admissions to children's assessment unit could be from either the emergency department or from home when children with long-term conditions had open access to the trust. Admissions to the day ward were elective with children attending from home. Admissions to Buxton ward were either elective admissions booked by the waiting list coordinator; emergency admissions received from the children's assessment unit; emergency admissions from the emergency department if the child did not require assessment on CAU first; transfers from other trusts; or open access patients. Buxton ward were limited to accepting eight surgical patients each day.
- Adolescents on Cringleford ward received free television and Wi-Fi access throughout their admission. This meant that they could choose the entertainment they watched, as well as having their social needs met while admitted to hospital.
- There was a learning disabilities specialist nurse to support patients living with learning disabilities throughout the trust. In the case of planned admissions, the nurse developed care plans with the child or adolescent and their family before admission.
- A light projector was used in the measurements room of the children's outpatient department. This meant that babies could be distracted whilst they were having their lengths and weights checked, thereby reducing any upset.
- A senior nurse coordinated end of life care for babies on the neonatal unit. Links were in place with a local children's hospice and a set pathway was in place. The nurse provided support to parents, as did the chaplaincy team, and continued support through the post mortem discussion. There was access to the bereavement lead nurse for the trust.

Meeting people's individual needs

- Children with complex needs did not always have their needs met. Parents of one child stated that a specific piece of equipment for their child was not supplied by the trust and they had to buy it themselves. The parents said they felt their child was "written off" because of their condition. Another parent said that their child required a cot but there were none available of a suitable size, and their child was unsafe to be left alone in a bed. This meant that they had to take their child with them when they needed the toilet. One parent said their child's complex needs were disregarded by a member of the medical staff and they felt their child "was discriminated against because of her condition".
- Information booklets were available in the neonatal unit that informed parents of support groups they could access. The booklets were specifically designed for families of neonatal babies, easy to read and provided information about the support groups and how to access them.
- Translation services were available within the children and young people's service, including leaflets and written information in a variety of languages. Staff were aware of how to request these leaflets.

Learning from complaints and concerns

- Between October 2014 and October 2015 there had been five complaints raised formally through the patient advice and liaison service (PALS) across the children and young people's service. There had been 16 concerns raised that had not developed into formal complaints. Complaints for the period November 2014 to October 2015 were reviewed with no trends identified.
- Feedback and outcomes from complaints and compliments were communicated to staff across all of the children and young people's service. Staff received emails with feedback, folders containing details and outcomes of complaints were placed throughout the service for staff to review, and nurses in charge communicated learning and feedback to their staff.
- Feedback to complainants was not always consistent. One parent stated they had complained eight weeks earlier and had still not received a response. Another parent said they had never received an apology from their verbal complaints but they did not wish to ostracise themselves by taking it further as their child had complex needs. Another parent stated that they had

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made a complaint about an incorrect 'do not attempt cardiopulmonary resuscitation' decision in their child's discharge paperwork, and this had been rectified in all subsequent paperwork.

- Staff from all areas of the children's and young people's service stated they would attempt to resolve complaints informally in the first instance. PALS leaflets were given to patients and carers in each case, giving information on how to access the PALS service for a more formal approach to handling their complaint.
- Staff provided an example of learning that had been included in the 'Buxton Bulletin', which was the sister's monthly newsletter. There had been a near miss incident recorded, and complaint, by the parent regarding administration of a feed to a baby; learning included the introduction of a two person sign off for administering feeds.

Are services for children and young people well-led?

Requires improvement



Well led was rated as requires improvement in the children and young people's service because;

- Staff across the service were unaware of how the new draft strategy would improve the service.
- Governance of issues such as security of children, checks of resuscitation equipment and controlled drug checks was not robust.
- There was no robust process to support staff providing care to mentally unwell children; no mental health nurses supported the service despite a limited number of staff having mental health competencies.

However;

- Staff were aware of the trust's vision and the trust's governance assurance pathway.
- There were clear processes of escalation from ward to board.
- Staff received regular communication regarding the service.
- Staff respected their leaders, and staff felt valued by their colleagues.
- There was a strong clinical research programme across all of the children and young people's service.

Vision and strategy for this service

- The board had not ratified the strategy for the children and young people's service. The expected date for this was December 2015. Staff across the service were not aware of how the strategy would improve the service. The draft strategy was linked to the organisational values of being people-focused, having respect, integrity, dedication and being excellent. The draft strategy focused on adolescents and young people making the transition from children's to adult's care, the development of services with specialist teams, participation in clinical research and improved partnership working with tertiary services and mental health care providers.
- Staff across the children and young people's service were aware of the trust's vision of providing care that they would want their loved ones to receive.

Governance, risk management and quality measurement

- A clear assurance pathway was in place from ward to board level in the children and young people's service. Issues such as incidents, risk registers, mortality, and audits were discussed at these meetings. There were individual governance meetings for children's medical, surgical and neonatal care. These three governance meetings provided an escalation pathway to an overall children's services governance meeting. This meeting provided a pathway into a divisional women's and children's governance meeting. The minutes for each of these governance meetings had a set format that meant areas for escalation to the next meeting up were categorised into caring and patient experience, safe (clinical and non-clinical), responsive, workforce, effectiveness and well led. These areas of escalation matched the four sub-board committees, which were the effectiveness committee, the workforce committee, the clinical safety sub-board and the responsiveness committee. This meant that clear areas requiring board level escalation received an appropriate level of scrutiny and focus at board level. This was evidenced in Board level meeting minutes.
- Despite a clear assurance pathway, not all clinical governance issues were identified. The lack of security measures on the children's day ward and Lion ward;

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inconsistent resuscitation equipment checks; inconsistent controlled drug checks; and lack of adherence to the trust's cytotoxic waste policy were not identified and therefore not escalated for action.

- The management of risks on the children and young people's service risk register was good. Initial scoring based on consequence and likelihood was given to described risks. Controls, assurances and ongoing monitoring of actions were recorded with clear review dates. There was evidence of the risk register being discussed at sub-board level.
- There was a clinical governance lead nurse for the children and young people's service, who provided regular monthly support to the children's medical, surgical, and neonatal care teams.
- Weekly meetings were held on the children's ward and the neonatal unit to keep staff informed of what was happening in the trust. There was a quarterly risk newsletter circulated within the children and young people's service that highlighted any learning and improvements to practice from any incidents and complaints.

Leadership of service

- There was a process in place for escalating to the executive team when a child was treated under a section of the Mental Health Act. Support was obtained from two nurses who had mental health competencies. However, no bank specialist psychiatric nurses were utilised despite no nurses having appropriate restraint training and most ward staff not having any mental health competencies.
- Leaders did not always support their staff to take breaks. For example, nurses on the children's day ward stated that they often did not take breaks throughout their shifts due to capacity and demand.
- Teams respected the local senior nurses in charge across all of the children and young people's service. Staff stated matrons were visible; however added that the director of nursing was not.
- Nurses in charge were experienced and capable of leading their teams. Processes were in place to support their staff with development and supervision. Responsibilities were delegated for particular tasks such as auditing.

Culture within the service

- There was a positive culture throughout the children and young people's service. Staff said they felt well supported, valued and that they would be happy for their children to be treated at the hospital.
- There was a low blame culture within the service. Staff felt that the complaints and incidents reporting processes promoted learning.
- While staff acknowledged that staffing levels were strained; they were keen to support any gaps in the service.
- There was a collaborative culture of care across the children and young people's service. Nursing staff stated they felt listened to and valued by medical staff. Staff felt their medical colleagues respected their individual skills.

Public engagement

- The trust held winter and summer fetes, which included inviting children to play with equipment from the service. This helped patients understand more about the service.
- The diabetes service had set up a sports day on World Diabetes Day, in conjunction with the local sports park. This day encouraged exercise and healthy living as well as providing advice and podcasts of support for diabetic children.

Staff engagement

- Staff were engaged in the service they worked in. Updates and feedback were circulated on what was happening in the service.
- Staff were involved in the implementation of changes from complaints and incidents, and staff were valued in their contribution to their teams by both their leaders and colleagues.

Innovation, improvement and sustainability

- A clinical risks assessment booklet was in the process of design to supplement patient records with clear risk assessments.
- The children and young people's service was proactive in clinical research. There were 14 active research studies being undertaken on the neonatal unit, with a further four studies being set up. There were 33 active research studies being undertaken throughout the rest of the children and young people's service, with a further nine studies being set up. This meant that the service was at the forefront of clinical innovation.

End of life care

Safe	Requires improvement	
Effective	Requires improvement	
Caring	Good	
Responsive	Requires improvement	
Well-led	Requires improvement	
Overall	Requires improvement	

Information about the service

Norfolk and Norwich Hospital provides end of life care to patients across all its clinical areas and treats a variety of conditions including cancer, cardiac and respiratory diseases, dementia and neurological conditions. The specialist palliative care team (SPCT) consisted of specialist consultants and nurses that provide advice, assessment and treatment to patients across all clinical areas within the hospital. Norfolk and Norwich Hospital did not have a dedicated ward for end of life care. The SPCT received 1750 referrals from April 2014 to March 2015, with 70% of these being for patients with a diagnosis of cancer. There were 454 deaths in the hospital between April 2014 and March 2015.

The director of nursing had responsibility for end of life care within the executive team. In addition, the bereavement office provided support to relatives and the chaplaincy service provided a 24-hour service for patients at the end of life, their relatives and staff.

During the inspection, we spoke with 10 patients and 13 relatives. We spoke with 55 members of staff including medical and nursing staff, allied health professionals, the SPCT, the director of nursing, porters, mortuary and chaplaincy staff. We reviewed 31 sets of patient notes and information requested by us and provided from the trust.

Summary of findings

End of life services at Norfolk and Norwich University Hospital required improvement overall. Safety, effectiveness, responsiveness and well led were all rated as requires improvement. Caring was rated as good for the service.

‘Do not attempt cardio-pulmonary resuscitation’ (DNACPR) forms were not always completed fully or accurately. The trusts DNACPR forms did not conform to national standards. The Liverpool Care Pathway (LCP) had been phased out of use at the trust. No standardised documentation pathway had fully replaced the LCP. The trust was using care-rounding forms to assess patients hourly for pain, comfort and hydration, and other key aspects of care. There was an incident reporting system in place however, this did not specifically capture incidents concerning patients at the end of their lives.

The trust did not have systems in place to make effective assessment of the quality of end of life care. The trust scored significantly worse than the national average in the latest national care of the dying audit, meeting only 47% of the key performance indicators. The trust does not participate in the gold standard framework accreditation scheme.

End of life care

There was no on-site seven-day specialist palliative care service at the trust. Out-of-hours end of life advice could be sought from the community nursing team. Staff across the trust were unsure of who to contact out of hours should advice be needed.

The specialist palliative care team (SPCT) had the vision to create a seven-day service at the trust for end of life patients. The director of nursing (DON), who was the executive lead for end of life care, supported this. The members of the SPCT did not believe the current staffing was sufficient to provide a seven-day service. The DON and the SPCT both stated the difficulties in achieving the vision were in part due to working with five different clinical commissioning groups (CCG) across Norfolk.

Patients at the end of life and their relatives were cared for with respect and compassion and in a way that considered their dignity.

Are end of life care services safe?

Requires improvement



Safe requires improvement because:

- We found examples on one ward where prescribing of medication did not always follow trust policies and national guidance and two examples where there were errors in prescriptions.
- There was little documentation around ceilings of care, (the maximum level of care and intervention planned), and preferred place of death / preferred place of care in most clinical areas.
- Current staffing numbers within the specialist palliative care team (SPCT) were below national guidance, with most working over their rostered hours.
- The mortuary management team deemed the trust's infection control training not suitable for the role of its staff, although staff have completed the training, as there is currently no replacement.
- All staff knew how to report an incident but not all knew what should be reported.

However:

- According to training records provided by the trust, three of the six SPCT nurses and half of the SPCT consultants had completed over 90% of mandatory training required for their role.
- Mortuary staff had completed over 90% of the necessary mandatory training required for their roles, with the exception of one member of staff. Chaplaincy staff had completed 100% of the mandatory training required for their roles.
- The mortuary's major incident and contingency plans for over capacity were appropriate and staff were fully aware of these.

Incidents

- The trust did not specifically record or audit incidents relating to end of life care. We reviewed incident data recorded between September 2014 and August 2015 and found that 43 incidents mentioned 'end of life care'. However, we felt this was not a true representation of the number of incidents involving end of life care happening at the trust. We found multiple incidents during the inspection that had not been reported.

End of life care

- Staff were aware of how to report incidents, but were unclear about what should be reported. There were two incidents that had not been reported in relation to air mattresses not being available for patients at risk of pressure damage. The trust subsequently told us that this expectation had been frequently communicated to staff by the director of nursing and tissue viability team to ensure prompt resolution of such issues as well as a means of identifying any additional requirements.
- The mortuary had 21 incidents reported within the last six months. Appropriate actions were taken following the incidents to mitigate future risk. Following incidents within the mortuary that had arisen from patients who had the same or similar names, the policy on admission and transfer of the deceased and the labelling of fridges had changed. The mortuary had a two-person check in place for all admissions and transfers out of the mortuary. Patients with the same or similar first or surnames were written in red on the fridge doors and on the admission paperwork to highlight the risk. No further incidents have occurred following changes to the policy.
- The Chaplaincy department were aware of how to report incidents and provided an example of when an incident had occurred and actions that had been taken in response.

Medicines

- The trust was currently implementing an electronic prescription system across all clinical areas. There were two examples on Elsing ward where medication was prescribed on the new electronic system and on paper prescription charts for the same patient. This increases the risk of medications being missed due to multiple prescribing locations.
- A further two prescriptions on Elsing ward were incorrect, with one being an incorrect medication dose prescribed for an end of life patient. The prescribing clinician had selected the wrong dose from a drop down menu within the new e-prescribing system. Another prescription was in contradiction to a national patient safety alert (NPSA). The consultant was unaware of the NPSA and there was no supporting documentation in the notes as to why the NPSA had not been followed. The consultant on Elsing ward was made aware of the NPSA contradiction.
- The anticipatory prescribing policy was being followed across the majority of clinical areas. However, on one

occasion anticipatory medication had not been prescribed in accordance with trust policy on the acute medical unit. This had also not been changed following transfer of the patient to Elsing ward. During the follow up inspection we reviewed medical records on Elsing ward and found that anticipatory medicines had been prescribed appropriately.

- Regular medications were being stopped in a timely fashion for patients at the end of life where it was no longer required.

Records

- The specialist palliative care team (SPCT) made detailed entries within the multidisciplinary notes. Documentation was clear and concise and considered all aspects of patient care. This was evident during a multidisciplinary handover on Mulbarton ward where all multidisciplinary notes were discussed and considered prior to changes in patients care plans.
- Documentation we reviewed did not reflect the fact that patients were at the end of life. This meant the potential for prolonging treatment in patients at the end of life. When we asked the SPCT they felt that there was a reluctance from clinicians to document that patients required end of life care.
- Nursing staff were using palliative care rounding forms to prompt them to see patients regularly to assess key areas of care. Care rounding forms prompt nursing staff to assess areas including breathlessness, agitation, nutrition and fluid intake, skin integrity and the involvement of family and friends in the decision making process.
- Completed palliative care rounding forms were evident in all wards that had patients at the end of life.
- Records showed that the preferred place of death (PPD) / preferred place of care (PPC) was not well documented across the trust. We reviewed 27 sets of notes linked for palliative or end of life care patients. 12 of the 27 had clearly documented a PPD/PPC and 15 had no PPD/PPC documented. The SPCT did an audit that showed 60% of SPCT referrals achieved their PPD/PPC. Staff had not completed audits for patients who were not referred to the SPCT, however an audit was planned for December 2015. No actions were in place at the time of inspection to improve these outcomes.

End of life care

- The mortuary records, including body release forms, medication register and booking in procedure, were accurate and matched the occupancy at the time of inspection.

Safeguarding

- An adult safeguarding lead nurse and adult safeguarding lead consultant had recently been appointed. This meant that a more joined up approach to safeguarding was now in place, allowing staff access to specialist support and advice.
- Training records showed that the SPCT had received safeguarding training appropriate to their role, including adult safeguarding level two and children's safeguarding level two. The SPCT were aware of how and when to report a safeguarding concern.
- A safeguarding concern was raised by the CQC to the lead consultant for adult safeguarding regarding an end of life patient during the inspection. This concern was dealt with swiftly, appropriately and cohesively and the Director of Nursing, who leads on safeguarding at executive level, gave feedback.

Mandatory training

- End of life care training was not currently part of the trust wide mandatory training. This was discussed and agreed at the workforce sub-board. Due to the heavy mandatory training requirements, it was agreed that this training should be accessible and encouraged, rather than mandated.
- Three of the six SPCT nurses had completed 100% of the trust's mandatory training appropriate to their roles at the time of the inspection. The other three SPCT nurses had completed between 66% and 75% of the trust's mandatory training, according to training records. The two SPCT consultants had completed 92% and 85% of the mandatory training required for their roles. The two registrars in the SPCT had completed 90% and 64% of their mandatory training. This training included safeguarding, infection control, manual handling and medicines management.
- All chaplaincy staff had completed 100% mandatory training required for their roles.
- Across all clinical areas we found 862 staff had received syringe driver training. Staff on Mulbarton ward were deemed competent following a period of supervised practice after attending training. No other clinical areas inspected had a similar system in place.

Infection Control

- All mortuary staff, with the exception one, had completed over 90% of the required mandatory training including infection control.
- Mortuary staff stated they felt the trust's current infection control training was not fit for purpose due to the nature of the chemicals used in cleaning the environment and the unique nature of their work. Staff said this issue had been raised previously with senior management but no alternative had been put in place. However, safe use and storage of the chemicals was observed within the mortuary.

Assessing and responding to patient risk

- The trust had a system in place to highlight patients who were at the end of their lives. End of life patients should have a blue border around their bed space on the electronic ward system for ease of identification, according to the SPCT. We did not observe this in use on any clinical area across the trust. During the follow up inspection, the blue border system was in use for two patients on Elsing ward.
- Ceilings of care were not widely documented. We reviewed 27 notes where ceilings of care would have been expected. Twenty did not contain clearly documented ceilings of care. This could result in inappropriate escalation of care, although no evidence was found to support this. In people who are entering the last weeks or days of life, the continued escalation of their care will often cause greater discomfort, compared to measures designed to maintain and promote comfort and dignity. Ceilings of care or treatment are often agreed between healthcare teams, and where possible, the patient or family so that if deterioration in their condition occurs suddenly, all involved in the care of that patient know how to proceed. A ceiling of care could include not escalating to intensive care or not performing resuscitation.
- Physiological observations were stopped when patients were at the end of their life in line with trust policy. Although no national guidance on stopping physiological observations exists, in patients at the end of life it is generally considered good practice to stop observations in the last hours of life. The need for

End of life care

physiological observation monitoring is to monitor for deterioration and support decisions to intervene with further medical treatment. In the last days or hours of life, this would be considered inappropriate.

Nurse Staffing

- Staffing levels for the specialist palliative care team (SPCT) were not in line with national guidance. The SPCT consisted of 4.4 whole time equivalent (WTE) clinical nurse specialists. SPCT provided a nursing service Monday to Friday with out-of-hours end of life care advice provided by community nurses. This practice is not in line with the Association of Palliative Medicine for Great Britain and Ireland, and the National Council for Palliative Care. The association recommends there should be a minimum of one specialist palliative care nurse per 250 beds. The trust currently has around 1,200 beds, meaning a quota of five WTE nurses to cover Monday to Friday only. Based on national recommendations, to provide a seven-day service the trust would require seven WTE specialist palliative care nurses.
- SPCT members felt staffing was insufficient for the current workload and said it was necessary to work beyond their rostered hours in order to see all referrals. SPCT members had not kept a record of excess hours worked, therefore no supporting evidence was found in relation to this.
- Palliative care 'link nurses' were on all wards we inspected. The link nurses had additional training to enable them to fulfil their roles.

Medical Staffing

- There were 1.3 WTE consultants in the SPCT. This is not in line with the Association of Palliative Medicine for Great Britain and Ireland, and the National Council for Palliative Care, which recommends there should be a minimum of one consultant to 250 beds to provide a Monday to Friday service. The trust currently has around 1,200 beds, meaning a quota of five WTE consultants.
- Palliative care consultants provided a Monday to Friday service but were on call over the weekends for any challenging referrals. The community nurses were also able to contact a consultant out of hours.

Major incident awareness and training

- The mortuary had contingency plans in place for overcapacity and for major incidents. These were robust and the overcapacity plans have previously been used to good effect. All mortuary staff had had major incident training in relation to their roles.

Are end of life care services effective?

Requires improvement



Effective requires improvement because:

- The trust's 'do not attempt cardio-pulmonary resuscitation' forms did not meet national standards and were not always completed correctly. Mental Capacity Assessments and Deprivation of Liberty Safeguards (DoLS) were not considered when necessary. Staff knowledge about the Mental Capacity Act and DoLS was limited.
- There were inconsistencies in the prescribing of effective pain relief. Staff did not always follow the trust's anticipatory medicines policy.
- Equipment, including air mattresses and syringe drivers, were often not available or difficult to obtain.
- A seven-day specialist palliative care service was currently not available. Out-of-hours, community nurses provided palliative care support.
- There was inconsistent engagement from non-palliative care consultants with the specialist palliative care team (SPCT).
- The trust achieved 47% of the 17 key performance indicators in the national care of the dying audit, scoring 6% for recognition of the dying patient. The national average was 61%.
- There was no comprehensive replacement for the Liverpool Care Pathway (LCP) implemented.

However:

- Provision of adequate nutrition and hydration to patients was observed throughout all clinical areas. There was effective multidisciplinary team working (MDT) on Mulbarton and Knapton wards between ward staff and allied health professionals.
- Information to support staff with patients at the end of life was easily accessible, both written and electronic via the trust's intranet site.

Evidence-based care and treatment

End of life care

- The trust had no one document to replace the LCP. This could lead to gaps in continuity of end of life care as each ward area could initiate and implement care in different ways and at different times. The trust was using hourly rounding forms to prompt nursing staff to assess the needs of patients at the end of life at least hourly. The hourly rounding forms were evidence based using the Leadership Alliance for the Dying 2014 and The Five Priorities of Care 2014.
- The trust did not participate in any national accreditation schemes such as the gold standard framework (GSF). The GSF provides training in relation to end of life care and an accreditation scheme for trusts that consistently meet national guidance.

Pain relief

- Prescribing of pain relief was generally in line with trust policy. We reviewed records on Gissing, Gunthorpe and Holt wards and all were completed appropriately with evidence of prompt administration on all three wards. With the exception of one patient, pain relief was correctly prescribed on Mulbarton ward.
- On Cringleford ward and the acute medical unit (AMU), there were delays in prescribing syringe drivers for end of life patients.
- On Dunston ward, a doctor was considering a syringe driver for 'poorly controlled pain' without a full pain assessment or medication review. This is not in line with the 'more care, less pathway' review into end of life care.
- One senior doctor on Elsing ward stated that he generally used the same starting dose of a particular opiate-based medicine for every patient and was unsure where to check for the correct dosage.

Equipment

- Staff on Cringleford, Knapton, Dunston and Gunthorpe wards raised concerns about the accessibility of syringe drivers and air mattresses. Staff said that syringe drivers were often difficult to get hold of causing delays in treatment. There was no evidence of completion of incident forms relating to this.
- Of the 43 incident forms that specifically mentioned end of life patients between September 2014 and August 2015, six related to unavailability of equipment, with one relating to a syringe driver and five relating to air mattresses. Two further incidents were highlighted whilst on inspection relating to the unavailability of air

mattresses; neither had been reported as incidents. Dunston ward also had delays in obtaining an air mattress. An incident form had been completed in this instance.

- Mortuary fridge temperatures were continuously monitored via switchboard. The fridges were 'banked' meaning not all fridges were running from the same system. This helped mitigate the risk of failure across all fridges within the mortuary at the same time. Mortuary staff were knowledgeable about the procedure in the event of failure of the fridges.

Nutrition and hydration

- Patients said that they were generally happy with the food on offer at the trust.
- Patients had drinks within easy reach or were routinely offered fluids throughout the day.
- In the latest national care of the dying audit, published May 2014, the trust failed to meet the national standard for patients' nutritional needs during the dying phase. The trust scored 22%, with the national average being 61%. Since the publication of the audit in May 2014, staff documented on the care rounding forms patients' nutritional intake.
- Throughout all clinical areas there was little evidence of documented assessments regarding patients ability and suitability to continue with oral food and drinks in the last hours and days of life. The specialist palliative care team (SPCT) confirmed that this was an area that was not well documented. The trust's policy for nutrition in end of life care stated that if patients were able to eat and drink this should be encouraged unless they chose not to.
- On one occasion, on Knapton ward, an end of life patient had a delayed assessment by a speech and language therapist resulting in the inability of the patient to eat.
- In all clinical areas inspected there was documented evidence on the palliative care rounding forms of nursing staff offering regular nutrition and hydration. This was also observed in many clinical areas.

Patient outcomes

- The results of the latest national care of the dying audit published in May 2014 demonstrated that the trust failed to meet the required standard for two of the seven organisational key performance indicators (KPI). They failed to meet KPI 1 access to specialist support in the

End of life care

last hours and days of life and KPI 7 formal feedback process for bereaved relatives. They also failed to meet the standard on seven of the ten clinical KPIs, scoring 6% for recognition of the dying patient. The England average for this KPI is 61%.

- We reviewed 27 sets of notes from patients who were at the end of their lives or receiving palliative care. Of the 27 notes, 17 had clearly documented that the patient was palliative or near the end of life. This suggests some improvement had been made. The next national care of the dying audit is due for publication in March 2016.
- Information was requested from the trust regarding their participation in the gold standard framework (GSF) accreditation scheme, or any other similar schemes. The GSF scheme is a national initiative to improve the care of patients at the end of life and awards trusts that consistently follow national guidance and deliver high quality care. The trust did not participate in the national initiative, or any other similar initiatives.
- The trust only participated in the national care of the dying audit but no other national initiatives or audits. Some local audits had been undertaken concerning 'do not attempt cardio-pulmonary resuscitation' forms and preferred place of death / preferred place of care for patients referred to the SPCT and oncology services.

Competent staff

- Kilverstone ward had a band six nurse released for 24 hours a month to train staff. The nurse is a qualified trainer for syringe drivers and delivers training when required.
- Palliative care 'link' nurses stated they had time out days for additional training relating to end of life care. Evidence to support this was provided by the trust.
- Due to staffing numbers, the mortuary team could not always be released to attend additional training over and above mandatory training.
- The porters stated that new members of staff were 'buddied' with experienced porters when carrying out mortuary duties.

Multidisciplinary working

- There was a resident physiotherapist, occupational therapist and social worker based on Mulbarton ward to assist in rapid discharge planning for end of life patients. The multidisciplinary handover was observed and

patients preferred place of death / preferred place of care, end of life wishes, do not resuscitate orders and specialist input were all discussed. Handover took place before morning ward round commenced.

- Knapton ward had an occupational therapist dedicated to coordinating discharges for patients whose preferred place of death / preferred place of care was at home. By having a designated professional focussing only on discharges home meant a more streamlined and coordinated service was in place for patients.
- Kilverston and Docking ward staff were positive about the chaplaincy service and their involvement within the multidisciplinary care of end of life patients.
- Coronary care unit (CCU) staff were aware of how to contact the specialist palliative care team (SPCT). CCU staff were positive about the input and care delivered by the SPCT.
- Medical referrals to the SPCT were varied amongst clinicians. One doctor on Dunston ward stated that the medical team did not often make referrals to the SPCT. The doctor told us he had never considered referring a patient to the SPCT. On Elsing ward, the medical staff consensus was that end of life patients were managed on the ward. No expansion on the justification was given for the lack of SPCT referrals.

Seven-day services

- The specialist palliative care team (SPCT) did not provide a seven-day service. The SPCT provided a Monday to Friday 8am to 4pm service. The local community nursing team provided cover during evenings, weekends and bank holidays.
- Staff within the trust had access to a 24 hour a day telephone service for end of life care. The community nursing team out of hours staffed this service. A SPCT consultant was available out of hours for the community nursing team to contact for medical advice.
- Staff knowledge of the out-of-hours system was varied and confused. Two senior nursing staff stated they were not aware of the 24 hour service. Both stated they had or would refer to their own medical teams or the site matron out of hours. Another stated they were aware of the 24 hour service but did not know who they were ringing out of hours. Another senior member of the nursing team stated that the out-of-hours number was for the local hospice and they provide the end of life advice.

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- The Chaplaincy service was available 7am to 7pm Monday to Friday in the hospital. Out of hours they provided a responsive service for any urgent referrals. The Chaplaincy aimed for a one-hour response out of hours and for urgent referrals during Monday to Friday daytime.
- Mortuary staff were on site during the day Monday to Friday. A mortuary assistant provided an emergency service out of hours, contactable via switchboard.

Access to information

- Medical notes and nursing notes were easily accessible within clinical areas when required. Ward based nursing staff were able to locate specific information within patient records. All members of the multidisciplinary team (MDT) documented in the same place. This meant all members of the MDT had access to all relevant notes.
- The specialist palliative care team (SPCT) introduced a 'pink folder' to all clinical areas. The 'pink folder' contained information relating to end of life care, including the referral process for the SPCT. Staff in all clinical areas knew of the 'pink folder' and where to find it.
- The 'pink folder' had only been in place for two weeks before the inspection. A 'quick link' had recently been put on the intranet home page for staff to access the palliative care pages. Due to this, not all staff were aware of the contents of the 'pink folder' and the intranet site.
- A syringe driver folder had been introduced to all clinical areas. The syringe driver folder contained information about setting up, programming and troubleshooting syringe drivers. Staff knew of the syringe driver folder and where to find it.
- The SPCT had a separate area of the staff intranet containing information on end of life care. Staff were aware of the intranet page and how to access it. Staff spoke positively about the SPCT and the ease of accessing information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed 27 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms. 16 of these were fully completed in line with trust policy. None of the DNACPR forms contained information on mental capacity in line with national guidance. In three cases there was no consultant signature and four forms had no, or inappropriate, reasoning for the DNACPR decision.

- The trust audited its DNACPR forms in September 2015. Of the 44 DNACPR forms audited, 34% had a consultant signature within 24 hours of completion and 23% had no discussion with either the patient or relative about the DNACPR being put in place. The audit showed that 91% of patients with capacity had the DNACPR discussed with them.
- The trust had created a local DNACPR form. Patients admitted with DNACPR forms in place from the community had them rewritten onto the trust forms on admission. Upon discharge, these were written back on to the recognised East of England DNACPR forms. This process had the potential of and increased risk of error through duplication or missed DNACPR on discharge. No data was available to support this, as errors are likely to be raised outside the hospital following discharge.
- The trust's DNACPR forms did not meet national standards as set out by the UK Resuscitation Council. The forms did not contain an area to document mental capacity and they were not carbonated to allow copies to be stored within patient notes. The trust's DNACPR forms had very small boxes for documenting discussions and reasons for the DNACPR. These were not clearly labelled on the form.
- The trust's DNACPR forms were the front cover of the admission booklet. This meant that the DNACPR form may not stay with the patient at all times as it was part of the nursing notes. There was the potential for patients who have a DNACPR form in place to be resuscitated by staff unfamiliar with the patient.
- Nursing staff on Knapton and Kilverstone wards were knowledgeable about the mental capacity act (MCA) and DoLS. We reviewed patient notes from Knapton ward where an active deprivation of liberty safeguards (DoLS) was in place. This had been completed appropriately and was reviewed on a daily basis in conjunction with the patients changing medical condition.
- On Holt ward there was a lack of understanding amongst nursing staff around DoLS. DoLS had not been considered when one might have been appropriate. It had been stated in one patient's records that they did not have capacity. No formal MCA assessment had been documented to support this.

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- Elsing ward had an end of life patient whose documentation stated they did not have capacity. No formal MCA assessment had been documented. A DoLS had not been considered when one might have been appropriate.
- On the critical care unit (CCU) staff used established end of life care pathways where appropriate these followed wider trust protocols. Each patient's resuscitation status, such as if they had a do not attempt resuscitation (DNACPR) order in place, was confirmed during nurse handovers. However, in two of 12 electronic patient records reviewed, a reason for the DNACPR was missing and in one record, there was no evidence of a discussion having taken place with the patient or their relatives
- The director of nursing (DON) stated that DNACPR completion and MCA and DoLS knowledge were areas of concern. The DNACPR, MCA and DoLS training was under review with the view to implement a plan for change in the near future. Funding had been secured for the emergency department to have additional training on MCA and DoLS. A date for the training was pending at the time of our inspection.
- Staff provided compassionate care in all clinical areas. Both nursing and medical staff communicated in a kind and gentle manner with patients and families. Staff took time to assist patients at the end of life to eat and drink in a calm and non-rushed way.
- Across all clinical areas that were inspected, patients' privacy and dignity was considered and appropriately maintained. Staff were fully aware of the importance of maintaining dignity, especially in the last days of life.
- On Weybourne Unit patients stated that the staff were kind and compassionate. Patients stated that staff were friendly and always sympathetic to their needs. Staff provided advice and support over the phone between chemotherapy treatments.
- A family on Cringleford ward stated that the care their relative was receiving was very good and spoke highly of the nursing staff and the way care was delivered.
- Patients and relatives on Hethel ward stated they felt cared for and staff were professional and empathetic. One patient said staff always pulled the curtains round the bed space before speaking to them to protect their privacy and dignity.
- Patients on the coronary care unit (CCU) stated that staff were polite and respectful and the care they received was fantastic. One patient described the nursing staff as "very caring" and described how they had offered both physical and psychological support throughout their treatment.
- NHS Blood and Transplant (NHSBT) team stated that they ensure any special items, requested by the patient or family, were wrapped with the patient after death. NHSBT team stated that they fasten the outer sheets with a butterfly after a patient has died as a mark of respect for the donation of an organ.
- Mortuary staff handled and treated the deceased with compassion and care. Mortuary staff stated that patients were arriving from the ward areas in an appropriate manner that indicated that care had been given after death.
- The mortuary fridge space was visible to anyone who entered the mortuary. This area was used for checking the identity of the deceased prior to transfer and therefore this procedure was visible. Staff had recognised this as a dignity issue and as a mitigating action, restricted access to this area had been introduced with only mortuary staff and trained porters provided access.

Are end of life care services caring?

Good



Caring was rated as good because:

- The vast majority of patients and relatives said that staff were kind, compassionate and caring.
- Staff from all professions maintained patients' privacy and dignity throughout the inspection.
- Services were in place via the chaplaincy team and the bereavement centre to support patients and relatives before and after death. Relatives felt included in the care decisions being made and felt their opinions were valued.

However:

- No formal psychological support or counselling services were provided by the trust for patients or relatives.

Compassionate and dignified care

End of life care

- The porters stated that they had no concerns over the care delivered to patients from ward staff or mortuary staff and believed that patients were cared for in a dignified manner.

Understanding and involvement of patients and those close to them

- Positive interactions happened between staff and patients and their family and relatives throughout the inspection. Staff on Mulbarton ward stated that relatives were encouraged to participate in the care provision for the patient. Staff gave an example of a family being involved in providing mouth care to their relative at the end of life.
- The Coronary Care Unit (CCU) had an example documented in detail within medical notes of the involvement of a family and the patient in the decision to implement a do not attempt cardio pulmonary resuscitation order. Staff on Gissing ward gave an example where they had involved a family in the decision-making around end of life care of a patient. Evidence of this was well documented within the patient's notes. It was not appropriate at the time to speak with the relatives or patient on the ward.
- A family on Cringleford ward stated that staff involved them within care decisions and kept them informed throughout treatment. Interactions between staff and the family were observed which took the family's wishes, and the patient's wishes, into account.
- The bereavement office staff organised for medical staff to be available when relatives came to collect the death certificate to answer questions relating to the death. This was something that was either arranged in advance or on the day.

Emotional support

- The chaplaincy provided spiritual and non-spiritual support to patients and families regardless of religious beliefs in times of crisis and distress.
- The bereavement office staff described themselves as a "safe space" for relatives to relax, ask questions and be supported before and after the death of a family member. The bereavement office offered families emotional support through informal discussions guided by the family.

- The bereavement office had the facility to host discussions between families and medical staff to answer any questions about the treatment of the deceased and provide reassurance and support throughout the process.
- The trust had no formal psychological or counselling support available to relatives of patients at the end of life. The trust had no plans at the time of inspection to introduce this service.
- Porters received 'time out' from the rota following the death of a child or baby to allow them time to reflect.

Are end of life care services responsive?

Requires improvement



End of life services were rated as requires improvement for responsive because:

- There was a lack of understanding amongst nursing and medical staff as to which patients should be referred to the specialist palliative care team (SPCT) and when.
- 70% of referrals in 2014/2015 were for patients with a cancer diagnosis.
- Staff on individual wards made referrals to the SPCT. The SPCT did not do a daily 'walk round' of clinical areas to establish patients at the end of life.
- Patients preferred place of death (PPD) / preferred place of care (PPC) was not being documented widely across all clinical areas.
- Within the mortuary, there was a lack of fridge space for the deceased. In September 2015, there were 15 days where the mortuary had less than 10 empty fridges. This resulted in additional pressure on the mortuary system in times of increased deaths.

However:

- The mortuary and bereavement office demonstrated learning from feedback.

Service planning and delivery to meet the needs of local people

- The specialist palliative care team (SPCT) stated that prior to 2015 they provided the 24 hour palliative care service for the hospital. At the beginning of 2015, after a clinical commissioning group (CCG) review, the out-of-hours service was moved to the community nursing team.

End of life care

- The SPCT stated this had had a detrimental effect on patient assessment and treatment outside of normal working hours. They stated that due to the community nurses not knowing the patients this had led to delayed implementation of end of life interventions. The SPCT had no data to support this. The SPCT stated that patients could not receive subcutaneous fluids in the community, which could prevent discharges. Again, no data was available to support this.
- The SPCT and the director of nursing (DON) both expressed difficulties in planning services as they had five clinical commissioning groups (CCGs) within the catchment area, each with differing views on how the end of life care service should be delivered.
- There were 1200 referrals to the SPCT in 2012/2013. This increased to 1400 in 2013/2014 and to 1621 for 2014/2015. The SPCT stated that 70% of referrals in 2014/2015 were for patients with a cancer diagnosis and 30% with non-cancer diagnosis.
- The SPCT relies on referrals from nursing or medical staff to identify end of life patients. The SPCT did not do a routine 'walk round' of the wards to establish end of life patients. The SPCT stated this was due to staffing with the team.
- The SPCT stated that 60% of patients referred to the team achieved their preferred place of death (PPD) / preferred place of care (PPC). They were unable to provide data for non-SPCT referrals. An audit of 78 patients with a cancer diagnosis over a 12-week period, beginning May 2015, showed that 79% of those audited achieved their PPD/PPC. The clinical lead for physiotherapy conducted this audit. A further four-month audit of those patients without a cancer diagnosis was due to be completed in February 2016.
- The trust did not have a specific palliative or end of life care ward. Patients at the end of life were cared for across the trust.
- On Mulbarton, Kilverston, Knapton and Gunthorpe wards facilities were available for families of end of life patients. These included comfortable seating, free car parking, refreshments and open visiting.
- On Kilverston ward a nurse stated that heart failure patients are not always identified as end of life as they "often bounce back", meaning to recover temporarily, following some treatment, which delayed the implementation of palliative care.
- On Mulbarton ward a patient stated that preferred place of death / preferred place of care had not been discussed with them by any staff.
- There were no facilities within the mortuary for the deceased to be out of the fridge for more than one hour. This limited the length of time families were able to spend with the deceased. There were no specific facilities within the mortuary to accommodate religious needs in terms of end of life rituals, for example allowing a family to wash the deceased. In exceptional circumstances, families were allowed to utilise the space between the fridges but this did not promote the privacy and dignity of the other deceased patients. No risk assessment was provided for this. No plans were in place at the time of the inspection to change equipment or practices to allow for additional time.

Access and flow

- The specialist palliative care team (SPCT) stated that there were currently 16 palliative care beds across Norfolk within the community. Accessing these beds was difficult due to the volume of patients and the low number of beds. No data was available on the number of patients requiring a palliative care bed within the community but not receiving one.
- The trust did not have a specialist palliative care ward or any specialist palliative care beds. There was evidence of end of life patients being given side rooms rather than being nursed in open bays.
- Capacity within the mortuary was limited at times; in September 2015 there were 16 days that were not declared as 'black days'. A 'black day' was declared when the mortuary has less than ten empty fridge spaces. Staff stated that increased numbers of black days was becoming increasingly common.
- The mortuary capacity was 104 fridges and 9 freezers, with access to a further 12 temporary fridges. There were specialist fridges for children less than one year of age but no specific space for children over one year of

Meeting people's individual needs

- The specialist palliative care team (SPCT) stated that following the Liverpool Care Pathways (LCP) removal the palliative care rounding forms had been introduced. The care rounding forms, along with individualised care plans written by ward nurses, ensured that each patient was assessed and individualised care delivered. Both care rounding forms and individualised care plans were seen in all clinical areas inspected.

End of life care

age. Staff would attempt to empty a bank of fridges to ensure a child over one year old was not in the same space as an adult but this was not always possible due to capacity issues.

- Portering staff stated that they had specific training on how to transport the deceased and had access twenty-four hours a day to the mortuary.

Learning from complaints and concerns

- The specialist palliative care team (SPCT) stated that they could not recall a time when practice had changed as a direct result of a complaint or concern raised by patients, families or staff. They also stated that no complaints about the SPCT service had been received.
- The bereavement office staff stated that families now collected the death certificate, could speak with a doctor and view the deceased on the same day following feedback from families.

Are end of life care services well-led?

Requires improvement



Well-led was rated as requires improvement because:

- Other than an increased service to seven days there was no clear vision, either trust wide or within the SPCT, for the end of life service. There was a strategy for the end of life care service which had been approved in January 2015 but was not well known by members of the nursing and medical teams.
- The vision to create a seven-day service within the trust was unsustainable with current staffing. Six business cases had been submitted for increased staffing within the SPCT. All six business cases had been refused. The SPCT were regularly working over and above their rostered hours to meet the demands of the service.
- The specialist palliative care team (SPCT) felt disconnected from the executive team. There was limited awareness amongst the executive team of the complexities of end of life care and lack of understanding from medical and nursing staff when referrals to the SPCT should be made.
- There were limited systems in place to allow the trust to monitor the quality of end of life care being delivered. The risk register for end of life care was limited containing two risks based around public perception of the trust.

- There was evidence of some public engagement, however this was limited and achieved through forums and meetings.

However:

- Both the SPCT and the director of nursing believed that there had been positive changes in end of life care following the appointment of the new chief executive and other senior management.

Vision and strategy for this service

- Other than an increased service to seven days there was no clear vision, either trust wide or within the SPCT, for the end of life service. A strategy for the service was also not openly discussed during the inspection and was not widely known amongst the varying staff groups.
- Following the inspection, documents were submitted by the trust detailing the ongoing implementation of the trust's end of life strategy. The strategy was approved in January 2015 and reviewed regularly since then. The end of life strategy itself had not been submitted, however the supporting documents showed that training of staff in end of life care and inconsistencies in documentation completion are ongoing concerns.
- Six business cases had been submitted for increasing staffing within the SPCT within the last six years. The SPCT had submitted five of the business cases, with the last one submitted by the divisional director eighteen months ago. All six business cases were refused on the grounds of funding.
- The specialist palliative care team (SPCT) stated that they wanted a seven-day service within the hospital. Increased staffing would enable the SPCT to engage with end of life patients who do not have a diagnosis of cancer.
- There was a disconnect between the SPCT and the executive team regarding staffing establishment to provide a seven day service. The DoN, as executive lead for the service, believed that a seven-day service could be achievable based on current staffing, however, the SPCT did not. Without a good working relationship between the SPCT and the executive team we were not assured that constructive engagement in planning and delivering futures goals would be implemented.

Governance, risk management and quality measurement

End of life care

- There was limited evidence that the executive board had a strong recognition for the complexities of EoLC or evidence to show the trust had systems in place to monitor the quality of the service. For example, no data was available for preferred place of care / preferred place of death for patients not referred to the SPCT, response times of the SPCT were not recorded and additional hours worked by the SPCT were not recorded.
- The trust entered the FAMCARE audit in September 2014. Out of the 100 families approached to participate, no responses were received. FAMCARE is a scale used to measure family satisfaction of patients with advanced cancer diagnosis. The trust planned to reenter the FAMCARE audit again in 2015.
- The 'more care, less pathway' report, published July 2013, recommended that all healthcare organisations appoint a non-executive member of the board, preferably a layperson, to oversee end of life care. The trust had not appointed a non-executive member of the board in line with the report's recommendations.
- 'More care, less pathway' also recommended that a yearly report should be submitted to the board for review to establish the quality of end of life provision across the organisation. This was not specifically undertaken at the Norfolk and Norwich NHS Trust but within the trust's governance structure end of life reported quarterly to the caring & patient experience sub-board as a minimum and subsequently to the executive and trust boards as it had been identified as an area requiring particular focus. The DoN fed back to the board on all areas which she led on, however no specific end of life review was submitted annually. This did not facilitate specific time to scrutinise the end of life plan and provide assurance of its effectiveness.
- The risk register for end of life care as produced by the trust had three entries. Two entries related to reputational damage from bad patient experiences and the third related to equipment storage on Hethel ward.
- The mortuary risk register contained two entries. One related to the loading bay and one to the post mortem benches. Both entries had risk reduction actions put in place to mitigate future injury; however, neither risk could be removed fully.

Leadership of service

- Both the SPCT and the director of nursing believed that there had been positive changes in end of life care

following the appointment of the new chief executive and other senior management. The director of nursing (DoN) felt the new leadership structured at the trust was having a positive impact on end of life care.

- However there was a disconnect between the view of the DoN, the SPCT and the wards. Staff on Mulbarton, Holt and Knapton wards were unaware that end of life care meant the last twelve months of life. Many wards managed end of life care insularly without referral to the SPCT which meant that there was continued improvement to be undertaken in the communication and role of the SPCT.
- The specialist palliative care team (SPCT) felt well supported within the team. The SPCT felt less supported by the trust executive board, stating the executive board were not as engaged with the service as they would like, particularly in relation to staff numbers within the team.

Culture within the service

- The SPCT felt there was a good team ethic within the team and felt well supported by local colleagues within the team. The SPCT also acknowledged that awareness of the importance of end of life care had improved over the last year, following a change of leadership at the trust.
- All staff acknowledged the importance of high quality end of life care and the majority spoke positively about the SPCT.
- The mortuary staff demonstrated a strong team ethic, describing themselves as "proud" of the services and care they deliver.

Public & Staff Engagement

- The director of nursing (DoN) stated that an opportunity to feedback was provided to families via the bereavement booklet but there had very little response. A discussion took place at the end of life steering group to decide whether or not the trust would actively seek feedback. It was formally agreed that this would not be undertaken at this time.
- The NHS Blood and Transplant (NHSBT) team held an organ donation committee meeting quarterly, chaired by the DoN. The committee included families, service users, mortuary staff, chaplaincy and NHSBT staff. The committee discussed aspects of, and ways of improving, end of life care for transplant patients.

End of life care

- A speech and language therapist represented the chaplaincy staff at directorate meetings. The chaplaincy also attended the end of life forum, which ran quarterly.
- On the coronary care unit staff stated they felt more support was needed from the specialist palliative care team (SPCT) in relation to heart failure patients. Staff on Dunston ward stated they felt more support was needed from the SPCT in relation to patients with motor neurone disease.

Innovation, improvement and sustainability

- 'A ward view' had started two weeks prior to the inspection. This was a new initiative to identify the number of end of life patients within the hospital. Due to the infancy of the initiative, no data was available.
- The trust was creating a proposal to work collaboratively with a neighbouring community

healthcare trust to establish an integrated palliative care network. The proposals detailed the want for a seven-day service and better acute and community partnership working to ensure patients at the end of life get the most appropriate treatment in the right setting.

- The bereavement office had streamlined the end of life service to enable relatives to collect the death certificate, speak with a doctor if they want and view the deceased in one visit. Reduction in relatives stress and inconvenience had been the trigger for change.
- At time of inspection, only one member of mortuary staff was able to do full reconstruction of the deceased following traumatic injury. The deputy manager would like to expand this service to all staff when funding becomes available. All mortuary staff were able to undertake partial reconstruction.

Outpatients and diagnostic imaging

Safe	Requires improvement	
Effective		
Caring	Good	
Responsive	Requires improvement	
Well-led	Good	
Overall	Requires improvement	

Information about the service

Norfolk and Norwich University NHS Foundation Trust provides outpatient and diagnostic imaging services from two locations. Norfolk and Norwich hospital and Cromer hospital. The Cromer and district hospital is situated to the north of the county, some 23 miles north of the main hospital site.

In 2014, there were 738,581 outpatient attendances at the trust, one of the highest numbers in the country. Outpatient services are provided for a wide range of specialties including anti-coagulant/venous thromboembolism (VTE), audiology, cardiology, radiology, respiratory, rheumatology, paediatrics, ophthalmology, physiotherapy, general surgery, ear, nose and throat (ENT), oncology-chemotherapy, dermatology, diabetes, trauma and orthopaedics, neurology, general medicine, and urology.

During this inspection we visited the main outpatient areas on both the Cromer and Norwich sites. We spoke with 133 members of staff. These included receptionists, nursing staff, allied healthcare professionals such as physiotherapists and radiographers, healthcare assistants, consultants, doctors, clinical directors, operational managers, heads of service, medical records manager, central booking manager, and administration managers. We spoke with 70 patients and 17 family members of patients. We looked at the patient environment, and observed waiting areas and clinics in operation. We also reviewed 24 sets of patient notes.

Summary of findings

Outpatient and diagnostic services were rated as good for caring, and well led, with safety and responsive rated as requires improvement, which gives a rating of requires improvement overall.

It was evident that there was a strong teamwork ethos with a large number of staff employed for many years within the trust. Staff were very passionate and proud of the services they offered to patients, and this was clearly reflected in the overwhelmingly positive feedback we received from the 70 patients we spoke with.

The trust had one of the highest numbers of outpatient clinics in the country. The capacity and flow of patients was managed by an internal waiting list system with confirmation letters of appointments sent to patients.

Incident reporting and correct identification of harm was not robust in either outpatients or radiology services. There had been four ophthalmic never events in the trust in last three years and two in dermatology in the last two years. The consistency of incident reporting was not robust, there was a limited number of staff trained to undertake root cause analysis, reporting responsibility sat with senior staff members, with little individual feedback, or learning. Incidents were not always classified correctly which resulted in under reporting. There had been three dermatology incidents that we raised with the trust as potentially meeting the

Outpatients and diagnostic imaging

never event criteria. The trust held a serious incident meeting at the end of November 2015 to review the incidents and two were raised retrospectively as never events.

Are outpatient and diagnostic imaging services safe?

Requires improvement



We rated outpatients and diagnostic imaging services as requiring improvement in terms of safety because;

- Incident reporting and correct identification of harm was not robust in either outpatients or radiology services.
- Nine percent of radiological incidents which occurred this financial year had not been reported to the Care Quality Commission in line with regulations, as they should have been.
- Staff understanding of the incident reporting process was fragmented. There was a limited appreciation of the need or value of reporting incidents to gain learning.
- There was a failure to recognise and report never events in line with national guidance.

However;

- There was a 24 hours, seven days a week service available for staff to track, trace, order and move notes for clinic preparation, which meant that staff should always have access to the hard copy patient notes for reviewing clinical histories and treatment plans, ahead of clinics.
- Trust staff were exceeding their target for safeguarding adult mandatory training completion across the directorate at 97%

Incidents

- There were four instances of never event incidents occurring within dermatology and ophthalmology departments between November 2014 and July 2015. During the inspection information was received regarding three dermatology incidents, between August 2014 and July 2015, that potentially met the never event criteria which we raised with the trust. The National Health Service England's definition of a 'never event' is "...serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers." The trust held a serious incident

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meeting at the end of November 2015 to review the incidents and two were raised retrospectively as never events. This meant that these incidents had not been reported in line with national policy until highlighted by us.

- The three potential never event incidents had been graded on the clinical incident reporting system as low harm however at least two had the potential for moderate to severe harm. This meant we were not assured that the correct classification of incidents was robust.
- Recording of RCA reports was also inconsistent. On review two of the dermatology RCA reports had the same incident number, which was an error. This again was rectified when we raised it with the trust.
- Recording of incidents was not robust. Most junior staff said they would pass details to their manager to report on the datix incident reporting system. However nursing staff in one outpatient's clinic area were able to relay from memory two incidents that had occurred within the last five months, which had been reported to their managers, but had not been put on the trust's clinical incident system for investigation.
- Nine percent of radiological incidents which occurred this financial year had not been reported to the Care Quality Commission in line with regulations, as they should have been. There were four incidents, out of a total of 43 that had not been reported.
- The trust had signed up collaboratively with the clinical commissioning group (CCG) to the 'speak out safely' campaign being run by the Nursing Times magazine, which encourages and supports nursing, medical, support staff and managers to raise concerns which will be investigated appropriately if they feel that a patient's safety is at risk. This was on the trust's website, but we did not hear any members of staff make reference to this safety campaign.
- One administrator said she had reported an administrative incident on datix four months ago, and had never heard the outcome of the investigation. She added that it was discouraging to not receive a response.
- The external imaging services accreditation scheme (ISAS) report stated that within radiology outpatients incident reporting turnaround times continued to far exceed the trust timescales, and appeared to be due to staff constraints.

- There was an organisational wide learning (OWL) publication to promote shared learning from incidents and never events. Both ophthalmology never events were shared in the January-April 2015 OWL publication to promote widespread learning.
- Clinics displayed on corridor notice boards accessible to both staff and patients '5 key learning points' on a monthly basis, sharing learning from incidents, but staff we spoke with appeared not to be familiar with the details of incidents. Staff were not consistently able to tell us about their departments most recent patient safety incident details, and it appeared that very little was relayed about the importance of reporting clinical incidents for learning purposes.
- Most staff were unable to clearly state how learning was shared from incidents. One administration manager said that incidents were discussed in divisional meetings, then at quarterly quality and safety meetings for wider learning. We saw evidence of learning outcomes from clinical incidents being discussed in the October 2015 radiology meeting minutes.

Duty of Candour

- Duty of candour is a legal responsibility of care providers to inform patients and apologise when an error has occurred in their care that results in moderate or significant harm. However the trust took the view that they wished to be open with patients in all incidents. This was evidenced through the dermatology never event incidents being reported on the trust's incident system as causing no harm, duty of candour was provided to the patients in both incidents. Junior nursing staff and administration staff within the respiratory outpatient clinic areas were not familiar with what this meant.

Cleanliness, infection control and hygiene

- The outpatients department at Cromer was visibly clean and 'I'm clean' laminated labels were used for equipment that had been cleaned.
- Alcohol hand gel dispensers were available at entrances to outpatient clinics to aid with staff and patient compliance with hygiene standards to prevent the spread of infectious diseases.
- Nursing and medical staff in outpatient areas adhered to the bare below the elbows infection control

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standards. Staff also wore colour coded uniforms and uniform keys were available on waiting room noticeboards for ease of identification of job roles by patients and relatives.

- The United Kingdom accreditation service (UKAS) undertook a third assessment of radiology services provided by Norwich, Cromer and Swanton Morley premises between the months of June-September 2015. This assessment was to confirm compliance with the imaging services accreditation scheme standard (ISAS) v2.1. The UKAS report, stated that within radiology regular audits are conducted jointly by the outsourced cleaning contractors and facilities on the cleanliness of the department which highlighted the need for repainting, and damaged floors to be repaired.
- The trust outsourced its environmental cleaning on the main Norwich site. Staff reported that the cleaning teams were not routinely cleaning under and over items, merely 'round' items. This meant that there was a risk of the spread of infection.
- There was a screening process in place for methicillin resistant staphylococcus aureus (MRSA). Patients requiring interventional procedures, such as a cardiology pacemaker, were advised via a clinic procedure letter that they needed to be clear of infections before becoming an inpatient in the hospital. The procedure letter explained what MRSA was, how it is dormant in most environments, but may cause an infection if it enters an open wound e.g. in surgical procedures. This letter explained that pre-procedure swabs would be taken to ensure the patient was safe to complete the procedure. Trust wide the infection control committee meeting demonstrated that between June – August 2015 the trust was testing 95-98% of elective patients for carrying MRSA.
- Hand hygiene audit results for radiological areas on the Norwich site and outpatients areas at Cromer for February and May 2015 all demonstrated 100% compliance with hygiene standards.
- Inside the hospital the signage was clear and the surroundings were visibly clean, fresh and tidy. There was ample space in the waiting rooms and the atmosphere was calm.
- Outpatient clinic areas had art on the wall, and there was an adjoining children's area decorated with beach huts and beach scenes. There was a television screen in the main waiting room providing details of clinics available with contact numbers for other services such as the NHS '111' service which provides fast, non-emergency help to patients.
- Two resuscitation trolleys were checked within the radiology suite within the accident and emergency department of the hospital. Each trolley received daily checks for completeness of contents and this detail was recorded.
- Risk assessments for clinic areas were not completed appropriately. A fire risk assessment had been completed for the neurology department. We requested a copy of this and found it to be incomplete, undated and unsigned by staff responsible.
- Within the trauma and orthopaedics clinic the fire risk assessment documented that a number of doors were either being purposefully propped open or did not fully close due to maintenance issues, and there was a record of equipment being stored in fire exit routes. These risks had been appropriately actioned with one low risk due for completion by the end of January 2016. This risk assessment had been dated but was not signed by staff with fire safety responsibility for the clinic area.
- There were radiology audits monitoring staff exposure to radiation levels and also lead coat exposure. The lead coat reviews were conducted annually listing items not fit for purpose as condemned. Most protective clothing items appeared to have a three year usable life span, but the lead coats in the interventional radiology unit (IRU) had not been tested since January 2012 and were therefore overdue for tests to ensure the safety of staff.
- The radiology department had a joint contract with a radiation protection advisor (RPA) with another local trust. The RPA worked on the Norwich site for two days a week, and provided twice yearly updates to changes in practice for staff.
- The March 2015 radiation protection advisor's report demonstrated the need for repeat environmental monitoring for two radiological breast imaging machines, one of which was located in the community

Environment and equipment

- Cromer hospital is a modern purpose built hospital that replaced the previous older trust building which no longer met required hygiene standards. There was ample car parking for patients at the front of the hospital including eight disabled parking bays immediately outside the hospital entrance.

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hospital. This report also recommended implementing regular eye and hand testing for high dose cardiologists, as well an investigation into the levels of radiation provided to a member of staff.

Medicines

- Medications were stored securely in all areas inspected. Drug cupboards were correctly locked at the time of our inspection within paediatric, trauma and orthopaedics, and rheumatology outpatient clinics.
- The trust used trust pharmacy forms to dispense outpatient medication, these forms were kept in a locked cupboard, within a locked room which a designated member of staff held the key for.

Records

- We reviewed 24 sets of notes at the main Norwich site. The trust used paper and electronic documents. Notes reviewed were in a poor state due to the age of the external folders. There were inconsistencies in recording on electronic/paper documents for allergies, mental capacity act (MCA) assessments, do not attempt cardio-pulmonary resuscitation (DNACPR) and 47% had loose sheets. Some of the sets of notes had four volumes spanning in excess of twenty-two years. The health records library manager advised that work was being completed to condense hard copy notes by utilising electronic scanning.
- One set of notes had a falls assessment template that was incomplete and contained minimal information. There was a score for the patient with no treatment plan or follow up for the patients' GP which meant that communication regarding continuing care did not include full information.
- Medical staff we spoke with in rheumatology told us that it was often difficult to find a patient's allergy status in the paper notes, and advised us that they often reviewed the discharge summaries for clarification.
- There was a shuttle service operating between hospital sites, including the health records library a couple of miles away from the main Norwich site, and this was how clinic notes were moved in preparation for outpatient clinics. We were assured that this process was secure with an online system for requesting and receiving sets of patient notes to aid with ease of locating.
- The average of patients seen in outpatient clinics without the full medical records being available was 4%.

- Within the ophthalmology outpatient clinics, patient notes were left outside consultation rooms on perspex shelves which were accessible to the public. Both sites were using laminated 'no entry' cards placed on top of notes, to dissuade unauthorised access but security of notes was not robust and could be accessed by anyone.
- The trust undertook a 'record keeping audit' in September 2015 which demonstrated some areas of compliance improvement on previous results such as key nursing care areas, but it also highlighted the following areas of concern for the 466 sets of notes audited;

- Only 57% of patient notes had the individual's next of kin documented.

- Completion of the supported discharge section had dropped to 37%.

- Completion of key data fields such as, previous *Clostridium difficile* (C. Diff), previous methicillin-resistant *Staphylococcus aureus* (MRSA), date of late menstrual period (LMP), possibility of pregnancy and pregnancy tests, all remained at a low level, as did documentation of date, time, signature, printed name, designation and contact number following first examination.

- The September summary report to the clinical safety sub-board cover sheet for the 2015 record keeping audit stated that the head of compliance governance would review and create an action plan for resubmission to the clinical safety sub-board in December 2015.
- The trust had a records and document management process that included off-site archiving. We were advised that there was a rolling programme to scan historical notes and minimise space required for physical storage of notes.

Safeguarding

- Safeguarding posters were displayed in patient areas on both the ground and first floor of Cromer hospital, and in clinic areas on the Norwich site; these contained contact telephone numbers for anyone to raise concerns within the trust.
- Mandatory training data showed that 97% of trust staff had met the requirement to complete safeguarding adults core training.
- Staff were aware of their responsibilities in regard to safeguarding. One senior nurse gave an example of a recent safeguarding incident that a member of the

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neurology receptionist team had recognised, reported and managed. Radiology staff gave a recent example of an incident where a safeguarding alert was made, and they described how their alert had received a good response from other trust staff.

- Staff members demonstrated that they held a good understanding of the Mental Capacity Act and were able to tell us where they would find trust guidance information on the staff intranet.
- There were 'Leeway' women's abuse support group posters in women's toilet areas with contact numbers. Leeway is a specialist domestic abuse charity supporting over 8000 adults, children and young people a year in Norfolk who are subjected to domestic violence. Safeguarding posters in patient areas around both trust sites displayed contacts for internal reporting.

Mandatory training

- Mandatory training for all staff included health and safety, fire safety, infection control, safeguarding children and adults, equality and diversity and information governance. This was delivered by face to face training, paper based and e-learning.
- Within Cromer outpatient department there was a matrix demonstrating staff's mandatory training requirements on the corridor noticeboard. Completion of training was monitored by senior staff and there was a plan to run a block-booking day for staff to complete a number of training sessions including manual handling and fire.
- Data provided for mandatory training compliance for rheumatology and radiology diagnostic unit (RDU) outpatient staff at Norwich demonstrated an overall average compliance of 79% which ranged between 60-93%, demonstrating child protection and safeguarding adults results respectively, for the month of July 2015.

Assessing and responding to patient risk

- The World Health Organisation (WHO) checklist was widely used in radiology and regularly audited across interventional radiology (IR), ultrasound (US) and computerised tomography (CT). However, this had not been instigated in mammography.
- There was a nursing induction training manual for registered nurses joining the general medicine and neurology outpatients departments. This stated that patients who become unwell whilst in the department

must be assessed by an appropriately trained member of staff and assistance from other team members or emergency teams should be sought and provided where needed. If necessary the patient may be referred to a doctor for advice or investigation and treatment using the situation, background, assessment, recommendation, and decision (SBARD tool).

- Outpatient waiting areas within the trust were open plan spaces which staff had visual access to in order to allow them to respond to any signs of potential risk promptly.
- There was an internal telephone system available to all staff who could access medical or security staff promptly if there was significant cause for concern.

Nursing staffing

- Bank and agency staff were utilised across the outpatient areas to cover any shortfalls in staffing numbers. Surgical and gynaecological outpatients' clinics were the greatest users of bank staff, at 32%, and 21% respectively.
- Plastic surgery were the only outpatient clinic area to have used agency staff in 2015, and agency equates to a sixth of their temporary staff usage for year to date, the remaining numbers are bank staff members.
- Bank staff undertake the same corporate and local induction processes as substantive staff. Agency staff completed local induction at the beginning of each new booking when they worked in a different area.
- Staffing numbers and skill mix for outpatient activity was reviewed as part of the annual business planning/ activity plan cycle on an annual basis. However we had concerns that not all staff knew the processes for reporting incidents or dealing with a safeguarding concern.
- Off duty sheets were not standardised across departments. Cardiology and Cromer outpatients used the e-rostering software for staff planning. Cromer outpatients matched its planned staffing levels with its actual numbers and the other departments off duty rotas did not clearly specify the planned staffing levels.
- We reviewed the planned and actual staffing rates from May to August 2015 and of the five specialities; clinical psychology, dietetics, occupational therapy, physiotherapy and speech and language therapy -

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dietetics consistently had the smallest shortfall at 0.30 whole time equivalent (WTE) staff per month. The largest gaps ranged between 2.51 to 4.44 WTE a month across clinical psychology and physiotherapy.

Medical staffing

- Some outpatient specialities had medical vacancies due to retention issues and long term sickness – neurology had two whole time equivalent (WTE) vacancies.
- There were eight WTE medical vacancies and three posts were currently vacant due to maternity leave within the cardiology technical speciality. Due to the service need the trust was having to use temporary agency staff to cover these vacancies.
- Radiology staff told us that they had had to change their shift patterns to meet service demand, adding that recruitment to posts was currently ongoing.
- There was a risk on the risk register in relation to arteriovenous fistula (AVF) and the loss of/damage to native vessels. This risk is linked to four clinical incidents. The radiology clinical director stated that a business case had been submitted to aid staff capacity issues, with a plan to integrate career progression opportunities, and to open a second interventional radiology unit (IRU).

Major incident awareness and training

- Staff in nursing, medical and administrative roles, all knew the major incident processes and where to find further information about it on the staff intranet.

Are outpatient and diagnostic imaging services effective?

Overall the outpatient and diagnostic services aimed to monitor their effectiveness through the use of audit, however there were concerns in relation to the consistency of the audit plan and completion of the full audit cycle to ensure quality improvements were implemented.

Patient feedback and friends and family test results were overwhelmingly positive for outpatient and diagnostic imaging clinics with an overall average of between 94-97% between April to September 2015.

Evidence-based care and treatment

- The trust demonstrated that it was participating in relevant national audits in order to benefit from

benchmarking and service improvements. Cardiology outpatients had registered for four national audits within 2015/16 which will be reported upon in the trust's quality accounts. The speciality is also participating in nine other local or regional audits, including one reviewing the transition of paediatrics to adult cardiac services.

- Rheumatology outpatient clinic nursing staff stated that medical staff were enrolling patients into the national registries as appropriate such as the British Society for Rheumatology biologics registers rheumatoid arthritis register (BSRBR-RA) and ankylosing spondylitis register (BSRBR-AS).
- The lead neurology nurse stated that the neurology outpatients' clinic at the Norwich site was 100% compliant with Neurophysiological Scientists guidelines and standards, and the international standard for clinical electrophysiology. Positive results had been received from participation in the 2014/15 national audit of neuro-monitoring services.
- We saw evidence of trust policies aligned to the National Institute of Health and Clinical Excellence (NICE) within the following outpatient clinics; gynaecology, [TA156, 2008] paediatrics [CG54, 2012, CG56, 2007], diabetes [CG119, 2011] maternity [CG62, 2007]
- Physiotherapy staff stated that there was an electronic system which alerted policy authors to their policy becoming due for renewal.
- There was inconsistency and confusion amongst some staff due to the use of terminology 'clinical audit and improvement' in relation to projects such as patient satisfaction data collection being registered as audits, yet containing no standards or criterion to monitor against.

Nutrition and hydration

- We didn't see staff offering patient drinks when they had been in the department a significant time.
- We did not observe intentional rounding within outpatient areas during the inspection.
- Patients and relatives had access to drinking water machines in waiting areas, there were kiosk machines available on level two of the east side and both east and west sides had access to café facilities, a shop selling basic goods, a high street retailer outlet and the main restaurant area on the ground floor of the central atrium.

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Pain relief

- Patient group directions (PGDs) were in use across the outpatient service. One example was the use of a topical pain relief cream in paediatrics, the PGD sign off sheet had been signed by three directors including; pharmacy and medical, as well as the PGD sub group chair and the drugs, therapeutics and medicines management chair. These signatures were recorded in 2014, with a review date of the PGD in December 2016. We reviewed 14 PGDs in use within outpatient clinic areas, two of the 14 were out of date in August 2015, one in paediatrics, and one in radiology.

Patient outcomes

- At trust level, there were 2.3 follow-up appointments for every new appointment, a similar rate to the England average of 2.2, indicating effective care.
- In March 2015 24% of clinics were cancelled. The most frequent reasons for cancellation were given as annual or study leave.
- We reviewed the trust's 2015/16 clinical audit plan, containing forty-five national audits spanning across both in and out-patient departments. The National Association for Diabetes inpatient audit (NAIDA) was not listed on this year's audit plan but confirmation of data submission was discussed in the diabetes clinical governance minutes in November.
- The outpatient clinic areas had a schedule of 93 planned clinical audits which took account for local and national guidelines such as the National Institute for Health and Clinical Excellence (NICE) and the Royal Colleges. Following the first wrong site surgery never event, an ophthalmology doctor conducted an audit of the WHO checklist. The first local audit was completed in 2014/15 and is reported to have instigated changes in working practices. We saw an audit registration for a follow up re-audit due to collect data in October 2015.
- The trust had gained accreditation in improving quality in physiological services (IQIPS) This meant that they were required to keep all protocols up to date.
- The imaging services accreditation scheme report stated that image quality audits had been carried out on pelvis and extremity examinations, with areas for improvement identified.

Competent staff

- The trust used specially trained nurses and health care assistants to lead clinics in cardiology and paediatrics.
- Staff confirmed they were either current with their appraisals or had staff appointments booked to achieve these. A senior nurse in cardiology said that the trust wide appraisals were moving towards being values based and this was currently being progressed with a working group.
- Dermatology outpatients told us that they had a departmental study day every September, which involves teaching sessions held in clinic areas.

Multidisciplinary working

- With the central booking service being managed in-house, the staff in the team had developed good working relationships in relation to regular contact for confirming availability on waiting lists with the administration managers for each out-patient speciality, and this enabled concerns about waiting times for individual patients to be escalated with onward referral for consultant decision, where appropriate.

Seven-day services

- Ophthalmology staff stated that weekend clinics were organised to help alleviate waiting lists allowing patients to be seen and treated quicker and make appointment times more accessible to patients without impacting on employment time.
- On review of governance meeting minutes, the impact of these additional clinics was that medical secretaries were not able to pick up the additional letter writing generated from these clinics, so further capacity was required to send out clinic letters in a timely manner.
- There was a consultant radiologist available to provide second opinions via an on-call system.
- Medical record note tracking and movement and patient waiting list appointment progression were provided as a seven day service.
- Radiology computerised tomography (CT) and magnetic resonance imaging (MRI) were provided seven days a week.

Access to information

- The trust had electronic systems in place for the recording of patient results and tests, but also still used paper patient notes for clinics. There was a shuttle system in place to transport notes from site to site in preparation for clinic and the central booking manager

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we spoke to advised that there was an electronic tracking system for easy identification of note locations. It was possible to request and move notes seven days a week. The health records library and ophthalmology departments had use of patient note bar code scanners to aid with the prompt dispatch of large numbers of notes.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Of the 24 sets of notes reviewed there was one which required escalation for appropriate mental health care. We did not see any reference to onward referral for this patient.
- Adult Mental Capacity Act (MCA) training compliance within outpatient departments was above the trust threshold at 97%, demonstrating high competency levels for staff being equipped to deal appropriately with patients affected by any mental health conditions. A number of staff groups were achieving 100% compliance, but the lowest scoring were medicine for the elderly staff at 85%, and ophthalmology staff at 89%.
- The trust's deprivation of liberties (DoLS) guideline asks staff to frequently consider whether any of their patients meet the criteria, and advised staff to use the appended DoLS checklist to make a formal assessment.
- Radiology staff told us that trust staff had access to online dementia training. They also said that there was not a named lead for dementia care in the department, but added that they felt that every radiographer should be able to support people with vulnerabilities.
- The trust had a dementia strategy, the aim was; "To provide dignified, compassionate, clinically effective and safe person-centred care for our patients who have dementia, by staff who are appropriately trained and who work in partnership with families and carers." Radiology administrative staff at Cromer said that they received face-to-face dementia training.

Are outpatient and diagnostic imaging services caring?

Good



Outpatients and diagnostic screening were rated as good for caring because;

- Staff were caring, compassionate and proud to work at the Norfolk and Norwich University Hospital NHS Foundation Trust.
- During our inspection we spoke with 70 patients as part of our inspection, and they were all very positive about the care and services they had received at the trust. Patients said that staff were approachable, friendly and helpful. The friends and family scores between April-September 2015 demonstrated 93-97% of outpatient and diagnostic imaging patients would recommend the trust.
- Clinics requested patient feedback and used this to improve the services they offered.
- A study and subsequent clinical audit had been carried out in paediatric radiology to use play techniques to distract children and reduce the need for general anaesthetics.
- Nurse led clinics were used to ease patients' experience of moving from paediatric to adult neurology clinics.
- Trust staff provided additional patient-focused time in order to explain processes and answer questions for patients with learning disabilities.
- Patients told us that outpatient clinics were busy, but well managed.

Compassionate care

- Consultant staff within the ENT clinic stated that they would extend an appointment to enable more time to be given to patients that were receiving bad news. They also said they would apologise to the patients following for having to wait longer.
- General surgery/urology outpatient clinics had ordered a 'chaperone' stamp which would be used to indicate in patient notes when a patient has used the chaperone service available to them, staff knew when this should be used and we saw evidence of this in the patient notes we reviewed.
- An end of life patient stated that he had been informed by a nurse on the Weybourne unit about signposting to financial help and that without this he would not have received the benefit.
- Patient interactions with reception staff were not private, which compromised privacy and dignity, this was not however, mentioned by any patients that we spoke to.
- Patients and relatives reported that staff were caring and compassionate, providing reasonable adjustments where appropriate.

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Understanding and involvement of patients and those close to them

- A paediatric brochure was sent to patients/parents ahead of the clinic appointment in radiology explaining what will happen within their magnetic resonance imaging (MRI) procedure. This eight page brochure was colourful with lots of pictures, and explanation of processes, and would benefit a nervous patient by providing easy to absorb information with pictures for ease of understanding. There was a book, designed by the play therapist, that helped minimise children's anxiety about the closeness of the MRI scanner. The therapist would also speak with patients individually on the day of their scan to help put them at ease.
- We reviewed friends and family response rates for six months between April - September 2015, the scores ranged from 94% for three months to 97% which was the highest score recorded in June 2015. We spoke with 17 relatives of patients who told us that they felt involved in their family member's care. Friends and family test results were 100% in the Weybourne Unit
- The trust introduced a comprehensive patient information letter in August 2015 providing details of how to book an appointment, procedure details, as well as other supportive information such as where to park, discharge advice, self-medication whilst in hospital, pharmacy contacts and information for overseas residents.

Emotional support

- Palliative cancer patients from the Weybourne unit spoke of how caring and supportive the staff were, adding that they were always able to answer any queries or concerns patients had; one patient said "they are absolutely brilliant".
- Paediatric radiology had developed a play-lead service to help children understand what was involved with their procedure, and this had been audited to demonstrate how this had had a positive reducing impact on the numbers of general anaesthetics required for this group of patients. The audit conducted was based on children aged 4-10 years of age. The data demonstrated a positive increase in the success rate of the scheme over the two years sampled, and for the

period January-June 2015 of the 82 patients involved, there was a 95% success rate for utilising this play-lead service rather than needing to use general anaesthetic to scan these children.

- Many outpatient clinics provided additional time allowances for patients with learning difficulties, to ensure that concerns about procedures and ongoing treatment could be discussed directly with patients to allay fears and anxiety.
- Neurology outpatients held nurse led clinics for 16-18 year old patients transitioning from paediatric to adult clinics which were designed to ease patients into an adult service. We were told that for familiarity, the same nurses treating patients in the paediatric clinic also saw the same patients in the adult clinic to help patients feel established in the new environment.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated outpatient and diagnostic services at the trust as requires improvement for responsiveness because;

- The trust was failing to meet its cancer 62 day referral to treatment targets at a 54% compliance average from August 2014 to July 2015 the target was 85%, and it was just missing its 31 day decision to treatment for surgery options for cancer patients at 92% with a target of 94% for the same period.
- The trauma and orthopaedic waiting area was identified as a space that could potentially compromise patient care, because the space was difficult for patients with limited mobility to manoeuvre around.
- There were limitations due to lack of physical space on the Norwich site to accommodate all the required outpatient clinics as demand increases. Clinics were utilising space effectively by sharing any spare spaces on an ad-hoc basis. The trust used external estates to provide treatment closer to many patients, many of whom were elderly.

However;

- The trust was managing a number of innovative projects and trials to aid patient flow and satisfaction.

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- There were a number of one-stop clinics such as urology, cardiology and dermatology being run to enable a patient to have a number of procedures and consultations within one visit to hospital.
- There was a waiting list management process in place to aid with the timely provision of outpatient appointments for patients required to wait over six weeks for their follow up appointments.

Service planning and delivery to meet the needs of local people

- Radiology outpatients at the Cromer site offer both an appointment based GP referral service as well as a walk-in system for both plain film and ultrasound and MRI scanning is also available. There is a significant older population in the Cromer area and these facilities avoid elderly patients travelling 23 miles to the main site.
- The trust had identified that staff knowledge of the 1886 breached RTT patient cases across 48 outpatient clinic areas had been minimal and had subsequently put in place an RTT plan to provide awareness to all staff members. This plan included the development of an access policy, an RTT training strategy for staff and roll-out of staff training all of which were due to be completed by the end of November 2015. The outpatient clinics which had the greatest numbers of breaches were; urology, general surgery, audiology and trauma and orthopaedics.
- For the month of October 2015 there had been 58 clinic cancellations, the highest cancellation rates were from; urology (24%), diabetes (12%) and audiology (9%).
- Review of central booking data in relation to waiting lists and allocation of patient appointments showed that outpatient breast clinics, surgery including vascular and varicose veins, gastroenterology - (hepatobiliary), cataract, gynaecological oncology, colposcopy, medicine for the elderly – general and falls, endocrine (including thyroid lumps), paediatric general medicine, cardiology, dermatology – (urticarial), rheumatology at both Norwich and Cromer sites, and nephrology clinics were all demonstrating capacity issues to meet patient and RTT demands.
- Effective team work was demonstrated in one-stop clinics at both the Cromer and Norwich sites for urology, dermatology and cardiology outpatient clinics. One patient said they had been in clinic at the Cromer site for a couple of hours and had had routine tests

undertaken, been seen by the Consultant, with a management plan being made before the clinical intervention was completed. This meant that the need for multiple visits to the hospital was reduced.

- Alongside the oral health clinic there was a lab of six technicians and a laboratory assistant that produced hand crafted prosthetics for patients requiring reconstruction following invasive maxillofacial treatment. Examples included hand painted eyes, cheekbones, jaws with teeth, and noses. This was a positive aspect for patients who lived locally, to enable them to influence the construction of these prosthetics.
- Complaints received by the trust were in relation to waiting times and staff attitudes, many patients across outpatient clinics said that parking was a big problem.

Access and flow

- The trusts did not attend (DNA) rate was around 4.5%, lower than the England average of 7.0%. There was a new appointment waiting list system in place to help reduce DNAs, this was effective but had large cost implications due to the significant number of staff in both the health records library and central booking teams, approximately 160 staff members who provided a 24/7 service
- There were a number of 'one-stop' clinics for urology, cardiology and dermatology. These were very effective as they allowed patients to complete a number of consultations and/or investigations within one visit to hospital ensuring tests were taken, and reported back in a timely manner.
- The 'patient pathway' is the route that a patient takes from their first contact with an NHS member of staff (usually their GP), through referral, to the completion of their treatment. For incomplete pathways, the trust met the RTT standard each month between April 2013 and September 2014 with a general downward trend. In October 2014, performance fell below the 95% standard and continued to fall to around 90% in May 2015.
- Between November 2014 and May 2015, the proportion of patients waiting six weeks or longer fluctuated largely in line with the England average. In May 2015, rates at the trust were 2% of all patients in May 2015, slightly higher than the England average of 1.8%.
- The trust states in its access policy that it will work to meet, and where possible – better, the maximum wait times set by NHS England of 18 weeks between initial

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referral to treatment, for all groups of patients. The average wait times for patients' first radiological appointment ranged between 1.2 and 6.4 weeks, with x-ray and MRI at the two extremes.

- The average wait time in clinic for patients to be seen for radiological review such as magnetic resonance imaging (MRI), x-ray, general computerised tomography (CT), general ultrasound and breast imaging was 25 minutes. The longest wait was for nuclear medicine which had an average wait time of 195 minutes.
- Clinics frequently ran behind time. During the inspection one clinic was running 40 minutes behind schedule. Another doctor on duty offered to assist by seeing patients that had been waiting.
- During the inspection patient said the thyroid clinic which was running 45 minutes late, and the gastroenterology clinic which was running 30 minutes late. Patients spoke of occasional 20 minute waits for adult diabetes clinics, and one elderly patient spoke of three consecutive clinic cancellations due to a lack of staff, which meant he missed his six monthly diabetic follow-up clinic.
- One patient stated that their GP had referred them to the eye clinic 12 months ago, they had had three appointment cancellations and not heard anything following the last cancellation. Review of data between August and October 2015 demonstrated that the average waiting time for an adult ophthalmic appointment was 5.8 weeks.
- One patient and their relative at the Cromer site had attended the one stop urology clinic. Within three hours they had an initial consultant appointment, a diagnostic procedure, an x-ray and a follow up appointment with the consultant again before leaving. Both were delighted with the service.
- In respiratory there was a chronic obstructive pulmonary disease (COPD) early supportive discharge clinic led by nursing staff. The nursing staffs attend the acute medical unit (AMU) to identify relevant patients then provide a seven day home support service.
- The lack of capacity within interventional radiology unit (IRU) had been incident reported twice and graded as moderate, due to the risk of patient deterioration whilst waiting for their procedure. This had been risk assessed and in early November 2015 it remained a severe risk due to 15 week waits for urgent referrals and up to 27 weeks for standard referrals. An IRU action plan was agreed at the end of October 2015, with an action to introduce a peripherally inserted central catheter (PICC) line service to patients at their bedside to help ease waiting list time for patients. The business case was approved in September 2015, with work now progressing to write job descriptions and policies to support this new service. Benefits of this new service listed in the business case included; a reduction in radiation exposure for patients and staff, increased turnaround time, follow-up and audit of patients with PICC lines.
- An identified risk on the trust's risk register was the waiting lists for radiology patients. The trust was providing between 6500 – 7000 radiology procedures a month.
- Due to capacity issues, the trust had to outsource some radiological procedures. This meant using mobile vans or sending patients to another provider. A review of a six month period demonstrated that x-rays were the lowest occurrence of outsourced procedures at (0%-0.5%), and magnetic resonance imaging (MRI) had the most outsourcing referrals (14%-20%).
- Some clinic areas were used on an ad-hoc basis to create additional capacity and reduce waiting times.
- Staff members demonstrated flexibility in their working patterns. Computerised tomography (CT) and magnetic resonance imaging (MRI) services were provided at the Norwich site to patients for extended hours between 7am and 8pm, and senior staff were extending their hours on these days to help with seeing patients on waiting lists.
- Rheumatology staff we spoke with told us that there was a good process in place to keep patients informed of clinic waiting times using noticeboards and announcements.

Meeting people's individual needs

- The trust send letters to patients when they have been asked to book themselves an appointment more than six weeks in advance. In these instances the trust sends speciality specific waiting list letters to patients advising them of the appropriate contact number for them to make their appointment booking. This letter contains any patient information specific to future procedures planned, and provides the opportunity to request interpretation services in advance of the consultation.
- The physiotherapy team leader told us most learning disability patients were treated in the community rather than at the Norfolk and Norwich University Hospital, and

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if patients did attend the trust according to availability, staff would aim to provide patients with a private room for their consultation. The physiotherapy team leader and the learning disability link nurse said that the care provided was reviewed only via the annual patient survey.

- Staff in the cardiology outpatients clinics stated that reasonable adjustments were made for their patients. Patients with learning disabilities were given extra clinic time to ask questions about their treatment plans. Staff in physiotherapy outpatients rarely have learning disability patients attend clinics in the east side at Norwich as they are usually treated in the community, but when they do attend there is a private room which can be used for their consultation.
- There was a learning difficulties link nurse for surgical and neurology outpatient clinic areas. They aimed to ensure that patients with learning difficulties were seen as quickly as possible to minimise anxiety levels. They ensured that patients had the opportunity to ask their doctor any questions they may have and encouraged the doctors to respond directly to the patient rather than responding to their carers. There was a learning difficulties trust-wide learning day that was open to all levels of staff to attend.

The radiology department had invested in larger aperture scanner for larger, clinically obese (bariatric) patients.

- Care Quality Commission radiology specialists reviewed the trust's 21 radiology incidents occurring between April and August 2015, and advised that 19% (4/21) had not been escalated to the commission in line with statutory notification regulations.
- Design of the fluoroscopy waiting area did not provide patients with dignity and respect, as they had to walk down the corridors in hospital gowns.

Learning from complaints and concerns

- On review of a whole year's worth of data (2014/15), complaints against outpatient clinics equated to 49% of the annual Trust complaints.
- Radiology staff told us that their outpatient department had learnt from complaints by providing patients with current waiting times for clinics in the form of details recorded on the notice board, and also verbal updates from staff, and following a complaint, new appointment letters had been amended for patients.

Are outpatient and diagnostic imaging services well-led?

Good



Outpatients and diagnostic imaging services were rated as good for well led because;

- There was a strong patient focused team spirit amongst staff members. Staff were proud to be part of the team, and worked hard to provide a high standard of care for their patients. Patient feedback was generally extremely positive about the caring nature of staff. Many staff members had been working for the trust for a significant number of years.
- Norwich and Cromer sites demonstrated innovative multidisciplinary team (MDT) working which enabled patients to have multiple consultations/tests/procedures completed within one visit to hospital which aided with patient anxiousness, and frustrations of travel and parking.
- There was on-going monitoring occurring in the form of risk register entries and clinical audits to help minimise the risks of reoccurrence of clinical incidents which had previously affected patient safety.
- There was innovative work that had improved paediatric patient services in radiology and within the venous thromboembolism (VTE) clinic which had resulted in a national award.
- Dermatology outpatients on the Norwich site had received national recognition for their work.

However;

- Not all clinical incidents were reported or classified appropriately.
- The Commission had previously highlighted concerns about there being a bullying culture within an outpatient area in the March 2015 inspection and these concerns were not allayed in November 2015.

Vision and strategy for this service

- The trust had a documented vision and strategy document, which outlined three key areas of focus;
 1. To provide first class quality services and excellent patient experience

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2.To establish a national reputation for excellent education, teaching and research

3.To enable all staff to realise their potential

Cardiology staff were the only outpatient area to refer to the trust values in our discussions.

- Computer screen savers displayed the trust's vision and values - people-focused, respect, integrity, dedication, excellence (PRIDE) displayed on computer screen-savers but staff were not always aware of these.
- There was a project underway to change the focus of annual appraisals to be based on trust values in 2016. This had been implemented as part of the trust's strategy to demonstrate staff engagement and an understanding of how their role fitted into the trust wide strategy and objectives.

Governance, risk management and quality measurement

- There was a robust process in place to manage risks. The outpatients risk register had three high concern (red) risks, which were reflective of concerns raised by staff from the outpatients and radiology departments and these were highlighted to us within discussions with senior staff members.
- General lower graded risk trends on the outpatient risk register highlighted that the trust was facing space issues for these clinics; this was verified by nursing staff and patients in clinics.
- Each risk regardless of red, amber, green (RAG) status had a clinical/operational director as the responsible owner.
- The trust works in partnership with the University of East Anglia which provided root cause analysis (RCA) training for senior clinical and risk support staff since 2005. We saw evidence that two-day 'critical incident investigations and human factors' training was provided by the university, in May 2015 for 17 members of staff from senior nursing teams which included; matrons/sisters, radiography, theatres, critical care outreach and risk staff members.
- Radiology staff told us that the monthly clinical governance meetings were positive and encouraged leads of services to share learning from complaints, for example leads would put up a list of waiting times for clinics in the clinic areas, and staff were able to relay to us changes that had been made to appointment letters

following receipt of patient complaint letters, however it was unclear how effective dissemination of information was following these meetings as more junior radiology staff members spoke of there being no shared learning from incidents.

- There was no robust monitoring of actions following RCAs to prevent reoccurrence, which meant that risk management was not effective.
- A risk assessment for evacuation of patients in an emergency had been completed by the neurology outpatients clinic, this had resulted in provision of a stairway evacuation chair (EVAC) as it had been recognised that there was insufficient lift space for wheelchair bound patients.
- Radiology feel pressurised by site teams within periods of black alerts (shortage of hospital beds), to provide a rapid turn-around of radiological reports in order to allow for the discharge of patients.

Leadership of service

- Local leadership was strong, with good team support and approachable managers. were friendly, approachable and helpful and appeared to work cohesively together with patients at the core of their work.
- Radiology staff reported that communication had improved with the new executive team.
- An external consultancy service had been employed by the trust to look into potential cost savings within radiology, but staff we spoke to voiced concerns that this would negatively affect patient safety.

Culture within the service

- Radiology staff explained that clinic space was limited and radiology and cardiology staff used shared space on a first come first served basis for outpatient appointments.
- Staff were aware of their duty to protect confidential patient information, and challenge staff members they did not know. There was also scrolling message on the computer screen savers prompting staff to remember not to disclose any information held on the trust's computer system unless it was via the appropriate channels.
- Staff had an awareness of the chief executive's 'viewpoint' sessions held monthly, but did not say they had participated in any.

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- We received reports of bullying and harassment behaviour within the radiology department on the Norwich site due to unclear definitions of roles and responsibilities. Within discussions with staff this appeared not to be systemic, but within a defined area of the department.

Public engagement

- Patient survey responses from November 2015 equating to 226 responses demonstrated the highest scoring categories applicable to outpatients and radiology, each scoring 90% were for; cleanliness, and dignity and respect. Lower scoring categories at 80% were for; staff co-operation and involvement in decisions. General positive comments were made about patients not feeling rushed, receiving caring treatment, and staff having time to answer any concerns patients had.

Staff engagement

- There was mixed feedback on staff engagement. Medical and nursing staff generally appeared to hold team brief meetings on a daily basis within outpatient clinics, but ophthalmology administrative staff were generally not involved in these meetings and therefore reported feeling out of the communication loop. This was a concern as the administration manager in each of the specialities is the person who coordinates the waiting lists and escalates any patient prioritisation concerns to the relevant consultant.

Innovation, improvement and sustainability

- The trust had contracted a large number of volunteers to assist with important duties such as welcoming patients on the front desks and advising them of the location of clinics, volunteers were also contracted to assist with moving patient notes from clinic to clinic. We spoke to a number of volunteers and they all said that they had required Disclosure and Barring Service (DBS) checking to perform their roles within the hospital.
- The radiology department had introduced a magnetic resonance imaging (MRI) led play therapy service for children. Clinical audit results demonstrated that the play therapy had a 98% success rate, which reduced the number of general anaesthetics required ahead of radiology procedures.
- Trauma and orthopaedics held a nurse-led lower limb cast clinic. Patients were provided with a venous thromboembolism (VTE) assessment, and if necessary prophylaxis was prescribed and the nurse and pharmacist educated the patient on administration, and provided the prescription drugs and sharps boxes for the patient to take home. This service won the British Nursing Journal award 2015. The drug protocol policy dated October 2015 distinguishes between the difference of using a PGD for defined drug quantities such as pain relief, and drug protocols (DPs) for drugs requiring variable dosing, such as the use of warfarin in the VTE clinics.

Outstanding practice and areas for improvement

Outstanding practice

- A specialist, midwife-led 'birth reflections' clinic was provided to support women who wanted to come to terms with their birth experiences.
- Clinical reporting and scheduling system in cardiology (Intellect) has been developed locally allowing the service to be more coordinated and efficient.
- There was an excellent primary percutaneous coronary intervention (PPCI) service providing prompt, effective treatment in line with national guidance and demonstrated good working with other providers and professionals.
- On Elsing ward we observed that the bays had been colour coded to assist patients moving around the ward and single use knitted sensory bands were available. Holt ward had refurbished a room to 1950's décor.
- The nursing team within the emergency department demonstrated outstanding care, leadership and treatment of patients.
- The innovation around trialling new ways and models of care including medicines administration within the emergency department, as well as the vision for the service was outstanding.
- The outcomes for trauma were outstanding and the best in the region.
- The local audit programme for nurses and medical staff within the emergency department was outstanding.
- The governance risk management, learning arrangements and staff willingness to continually strive to be better for the patients in the emergency department was outstanding.

Areas for improvement

Action the hospital MUST take to improve

- Ensure that patient acuity is properly assessed and there are adequate medical, nursing and midwifery staff to care for patients in line with national guidance.
- Follow infection control principles when cohorting patients.
- Ensure that all children's inpatient wards and units have adequate security measures in place to reduce the risk of children absconding and unauthorised adults gaining entry.
- Ensure that incidents are investigated in a timely way by trained investigators, graded, and reported in line with current national guidance.
- Ensure that the management of outliers on Cley ward are properly assessed and provided with safe care.
- Ensure that the management of referrals into the organisation reflects national guidance in order that the backlog of patients on an 18 week pathway are seen.
- The trust must ensure that patient records are legible, accurate, complete and contemporaneous for each service user, taking into account the use of both hard and electronic records.
- The trust must review 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms to ensure they are completed fully and in line with trust policy and national guidance.
- The trust must review its Mental Capacity Assessment and Deprivation of Liberty Safeguarding process and the way this is documented within patients' notes – Regulation 17(2) (c).
- The trust must ensure that staff within the radiology department have access to appropriate support, supervision and appraisal.
- Ensure that compliance to mandatory training is met and ensure consistent compliance across all clinical staff groups. Ensure that training is relevant to meet the needs of those in specific roles such as staff in the mortuary.
- Ensure that medicines are stored and administered in line with national guidance.
- The trust must review and improve the environment of the children's emergency department to ensure that the environment is fit for purpose and safe for children to receive care.

Outstanding practice and areas for improvement

- Review the staffing of the children's emergency department to ensure that there are sufficient numbers of registered children's nurses on duty at all times.
- The trust must ensure that there is an increase awareness of the complexities of end of life care, including a defined strategy and vision, increased involvement and referrals to the SPCT and improvement in performance indicators specifically recognition of the dying patient.

Action the hospital SHOULD take to improve

- Closely monitor transfers to Mattishall ward and the environment should be improved in line with the development plan for the unit.
- The trust should reconsider the ambulatory care pathway in the AMU.
- Review the availability of adequate equipment for patients to sit out of bed if clinically able to do so.
- Review the permanent clinical leadership in AMU.
- Ensure a robust process for checking of emergency equipment.
- The trust should review its risk management and escalation policies with respect to how clinical staff raise concerns and ensure these are acted upon appropriately.
- Reduce readmission rates for children and young people with long-term conditions.
- Review the provision of information technology for community midwifery teams
- Review mechanisms for supervision and appraisal for all staff so that they are supported effectively.
- Develop an action plan to address the lack of improvement in the completion of discharge information in the specific safeguarding children paperwork for use within the maternity departments.
- Review the provision of adequate seating in the antenatal clinic.
- Reduce the number of cancelled gynaecology clinics.
- Review the ratified guidelines within the obstetric assessment unit and ensure that it is located in an area where it can operate effectively.
- Put procedures in place to reduce the number of closures of the obstetric unit.
- Review the staff understanding of the vision and strategy for their areas.
- Review fluoroscopy changing areas and process to ensure patient privacy and dignity is maintained.
- Ensure that doctors within the emergency department adhere to bare below the elbow policy requirements.
- Improve the culture amongst the consultant body within the emergency department.
- Improve the culture of the organisation towards the emergency department to reduce the feeling of blame for targets not being achieved.
- Review the bed management process and site management processes within the organisation to increase capacity and flow.
- Improve systems and processes for the declaration of black alert to ensure that it contains tangible changes designed to improve the service, i.e. daily consultant or nurse led discharges.
- Review the emergency department triage process to ensure that all patients are offered pain relief where it is required.
- Review the plans for expanding the main emergency department and make a decision swiftly on the future expansion of the service.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Maternity and midwifery services	There were insufficient numbers of appropriately trained and competent staff to meet the dependency of patients, particularly on a night shift and within the ED for paediatric patients. This impacted upon the safe care and treatment of patients particularly in ED, medical, surgical and maternity wards.
Surgical procedures	Infection control principles were not being followed in some areas of the hospital. This included the poor cohorting of patients in medicine and children's services, medical staff not adhering to the bare below elbows policy in ED, the decontamination of scopes in Surgery, lack of hand gel in maternity and the issues raised in the mortuary.
Treatment of disease, disorder or injury	The security of the children's areas, Lion Ward and the children's day ward, was not maintained.
	Risk of harm is managed through the clinical harm group, mitigating a safety concern of patients on waiting lists. However the responsiveness to manage referral to treatment time (RTT) in relation to access and flow and capacity was not as effective as it could be to ensure that the trust was responsive to meet the patients' needs.
	Radiology, midwifery and some nursing staff did not have the access to appropriate supervision or appraisal.
	Mandatory training to support staff in caring for patients was not robustly enforced or appropriate to the needs of specific staff.
	Medicines were not always stored in line with national guidance.

This section is primarily information for the provider

Requirement notices

The trust has not ensured that the premises used by the service provider, in respect of the children's emergency department, are safe to use for their intended purpose because the waiting area was very small and was not able to accommodate the volume of children and parents attending. There was no facility to provide high dependency or emergency care to children outside of the resuscitation department.

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider was failing to ensure that each service user had an accurate, complete and contemporaneous record of their care including Do Not Attempt Cardio Pulmonary Resuscitation and had failed to ensure a consistent approach to end of life care pathway.

Mental Capacity Assessment and Deprivation of Liberty Safeguarding process were not always in place and documented within patients' notes. Staffs understanding of these processes were limited across the hospital.