Norfolk and Norwich University Hospitals NHS Foundation Trust

Quality Report

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This report describes our judgement of the quality of care at this trust. 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 trust	Requires improvement
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	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 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 4 and 6 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 were 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' abilities 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 outpatients 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.
- A 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. 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 were 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 increased awareness of the complexities of end of life care, including a defined

Summary of findings

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:

- Closely monitor transfers to Mattishall ward and the environment should be improved in line with the development plan for the unit.
- 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.
- 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

Background to Norfolk and Norwich University Hospitals NHS Foundation Trust

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

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.)

Summary of findings

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 10 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.

What people who use the trust's services say

There were two listening events held: one on 4 November 2015 in Cromer and a second on 20 November in Norwich.

Both events were poorly attended, with only six attendees at the Cromer event and 15 at the Norwich event.

However, there were overwhelmingly positive accounts of treatment and support for the local site at Cromer, with a theme of wanting more service provision rather than less. Patients expressed disappointment that the endoscopy service had been reallocated to the main Norfolk and Norwich site.

We heard mixed accounts of the care provided at the Norwich event. Patients and relatives felt that the shortages of staff were impacting on the care being provided.

Facts and data about this trust

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.

Summary of findings

- 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.

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

  • **Beds**: 1,237

  – 1,167 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 four 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

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? Overall we rated the safety of services as 'requires improvement'. This was because: • There was an overall shortage of nursing staff which impacted on the care provided. Nurse staffing did not reflect the acuity of patients on all wards and we raised this concern during our inspection. • In critical care, maternity and the specialist palliative care teams there was a shortage of medical staff to provide cover in line with national guidance. • On-site medical support at the Henderson unit was minimal. This had been raised as a concern from our previous inspection in March 2015. • Incident reporting was generally well completed but root cause analysis was poor or undertaken by staff who were not trained to do this. Classification of harm following an incident was not robust which meant that not all incidents were reported appropriately. • Management and oversight of risks at the Cromer site needed to improve. Review dates for risk assessments for control of substances hazardous to health (COSHH) were outstanding, with one last reviewed May 2012. • Some improvement had been made to Mattishall ward however the environment 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. We were also concerned that patients not meeting the referral criteria for Mattishall ward were routinely admitted to that ward. • Infection control practices were not consistently applied throughout the hospital. • Medicines were generally stored and administered correctly, although security of medicines was varied and was not robustly monitored in all areas. However we also found that: • Staff were aware of the learning from incidents. • Records were generally well completed, of good quality; risk assessments completed and updated in response to changing needs.	**Requires improvement** 

Summary of findings

- Safeguarding processes were well known to staff and staff were aware of their safeguarding responsibilities but training levels for safeguarding training were below trust target as was other mandatory training.

Duty of Candour

- Senior staff were aware of the need to meet this new regulation. Systems and processes were in place to ensure that patients and those close to them were provided with an explanation when things went wrong for all incidents graded moderate harm and above.
- Most staff on the ward areas were also aware of their responsibilities under the regulation and could verbalise this to our inspection teams.
- Staff stated that duty of candour discussions should be recorded in the notes. A template letter was available and a process in place for an email alert to be sent to the clinical lead and matron when duty of candour had been met. However this process and recording in notes had not been audited.

Safeguarding

- The trust met their target of having 75% of all staff completing the mandatory training on Safeguarding Children (Level 1). At Norfolk and Norwich University Hospital, 84% of staff had completed Safeguarding Adults training, and 68% and 76% of relevant staff had completed Safeguarding Children Level 2 and Level 3 training respectively.
- The named safeguarding children lead was new in post, having been recruited in July 2015.They had been proactive and provided examples of change since being in post. These included changing staff perceptions, by encouraging staff to have a 'think family' approach, more visibility on wards and in the emergency department, identification of domestic abuse champions and attendance at the central steering group.
- Nursing staff stated that the safeguarding lead was very supportive however they also felt that support from more senior staff was limited and that the matrons found safeguarding difficult.
- The target of level 3 training was low at 75% compliance. Originally the target had been 90% by 2017. The trust had an upward trajectory for compliance. At November 2015 this was 85%.
- There were concerns with aspects of the level 3 training such as minimal training for trainers and separate training for medical

staff. There were safeguarding champions throughout the trust to deliver training however they had only received a three-hour, in-house, "train the trainer" training session in order to prepare them for this.

Incidents

- The trust reported 111 serious incidents between August 2014 and July 2015. 40% of the serious incidents were classified as pressure ulcers, and a further 30% were reported to be slips, trips or falls.
- Incident reporting and correct identification and classification of harm was not robust at either site. There had been four ophthalmic never events in the trust in last three years and two in dermatology in the last two years. There had been three dermatology incidents, at the Norwich site, that we raised with the Trust as potentially 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. Therefore at the time of our inspection neither of the dermatology never events had been reported in line with national policy.
- There had been one incident of wrong site gynaecology surgery at Cromer hospital in July 2015 that had been investigated but it had been decided by the trust that this was not a never event.
- Communication of lessons learnt from incidents between the two sites, Cromer and Norfolk and Norwich hospital, was 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 each site, within six months of each other. Both involved wrong site surgery by an injection undertaken into the incorrect eye. Staff stated that changes to the operative documentation had occurred at the Norwich site but had not been implemented at Cromer. Changes in process following the incidents also differed and were not consistent. Patients at Norwich had a red wrist band on their arm to indicate the side to be operated on however the process in Cromer is that the patient's forehead was marked.
- There were no local audits or measurement of the quality of the World Health Organisation (WHO) checklists at either Cromer or Norwich sites. 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.
- Management and oversight of risks at the Cromer site needed to improve. Review dates for risk assessments for control of substances hazardous to health (COSHH) were outstanding, with one last reviewed May 2012.
- Investigation of incidents was 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 root cause analysis (RCA).

Staffing

- Nursing 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.
- Nurse staffing did not reflect the acuity of patients on the wards. There were a high number of vacancies and registered nurse gaps were frequently filled with healthcare assistant hours.
- Some areas of nurse staffing were significantly below the national standard, such as the real time ratio of one whole time equivalent midwife to 34 births and the current staffing numbers within the specialist palliative care team (SPCT).
- Medical staffing numbers did not always meet those of nationally recognised guidance. Consultant obstetric cover in the delivery suite was 60 hours a week which was significantly less than the Royal College of Obstetrics and Gynaecology (RCOG) guidance of 198 hours a week for a unit of this size. Overnight and weekend consultant cover in the critical care complex (CCC) did not meet ICS core standards for intensive care units.
- On-site medical support at the Henderson unit was minimal (two days a week) and though an inpatient service, the unit was reliant on out-of-hours community medical services overnight and weekends.This was an outstanding concern from our previous inspection in March 2015. Due to the minimal medical provision on site, medications could be prescribed without a patient review by a clinician.

Cleanliness, infection control and hygiene

- A shortage of side rooms in the acute medical units meant that at times patients were cohorted into bays. One senior member of staff said that 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.
- The director of infection prevention and control (DIPC) was enthusiastic and motivated. An electronic webpage had been designed that provided infection alerts and communication across the trust. This meant that the DIPC, alongside the IPC team, could review the status of methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile easily and efficiently.
- Processing of flexible endoscopes, within main theatres, was not undertaken, monitored or recorded appropriately to ensure patient safety and minimise the risk of infection. There was a paper system was in place to record cleaning, decontamination and use of each scope against patient details to ensure traceability. However 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.
- 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.
- 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.

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 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.

Medicines

- Medicines were generally kept securely behind closed doors on all wards and departments as per hospital policy however there were areas where this was not consistent such as the intensive care unit, postnatal ward and delivery suite and children's wards, where medicines were at risk of theft or tampering.
- 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.
- 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.

Are services at this trust effective?

We rated the effectiveness of services as 'requires improvement' overall because we found that:

Requires improvement

- Staff were not always aware of the need to assess a patient's capacity to consent to care and treatment. There was confusion as to when a mental capacity assessment should be undertaken.
- 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) forms were not completed fully and in line with trust policy and national guidance.
- There was a lack of care planning to ensure that those at the end of their lives received effective care.
- Appraisal rates were below trajectory across the trust.

However we also found that:

- The hospital performed well in a number of audits including the Myocardial Ischaemia National Audit Project (MINAP).
- There was evidence of good multidisciplinary working across the service.
- Care was delivered in line with national guidance which was available for all staff.

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 all areas to monitor acutely ill patients in accordance with NICE guidance CG50.
- Care was provided via care bundles which adhered to national guidance. The Trust provided training on the use of these. We reviewed notes where care bundles had been used and found that these were completed appropriately.
- There was clear evidence of ongoing local audit activity within the trust, with audit programmes identifying nominated audit leads, rationale, methodology, results, associated action plans, improvements, and re-audit cycle.
- 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 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.
- Both medical and nursing staff were able to describe audits that had been undertaken and actions taken to improve services.

Patient outcomes

- For 2014 the Summary Hospital Mortality Indicator (SHMI) level for this trust was 1.019.
- The Intensive Care National Audit Research Centre (ICNARC) 2014/15, data showed that the critical care unit performed better than the national average for hospital mortality.
- Between July 2014 and June 2015 the Hospital Standard Mortality Ratio (HSMR) in this trust was 104.5, with a score of 105.7 during the week and 104.4 at the weekend.
- There were no mortality outliers for this trust in the May 2015 CQC Intelligent Monitoring Report.
- The trust took part in the 2012/13 Heart Failure Audit. The trust had good results over all, 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. 58% of patients were admitted to a cardiac unit or ward, compared to an England average of 56%. 79% of patients were referred for or had an angiography, compared to the England average of 78%.
- The endoscopy suite had been accredited by the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) in January 2015.
- 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.

Summary of findings

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 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 trust varied across specialties with staff shortages cited as the main reason why compliance rate was not always fulfilled. There was a plan that part of the development of the divisional nurse director roles was to cover and support appraisal completion.
- 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.
- 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.
- Supervisors of midwives (SoMs) help midwives provide safe care and were accountable to the local supervising authority midwifery officer (LSAMO). There were less SoMs than national guidelines recommended, with less time to complete the role.

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 (MDT) including nurses, doctors, therapists and discharge coordinators discussed the plan and needs of patients.
- 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.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- 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.
- Four sets of records reviewed within medicine 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.
- 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 small number, particularly given the variable understanding of staff of the Mental Capacity Act.
- 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, decisions had been made about their care by staff and 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.
- 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 an 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 is part of the nursing notes. There is the potential for patients who have a DNACPR form in place to be resuscitated by staff unfamiliar with the patient.
- 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.

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 Gillick competence.

Are services at this trust caring?

Good

We rated the trust as proving care which was "Good" because:

- The NHS Friends and Family Test (FFT) scores were generally very positive for all wards.
- There were many examples observed 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 through referral for ongoing care.
- A specialist, midwife-led 'birth reflections' clinic was provided to support women who wanted to come to terms with their birth experiences.

Compassionate care

- The trust's Friends and Family Test performance was generally better than the England average between July 2014 and June 2015. In June 2015 trust performance was 96.4% compared to a national average of 96.0%
- In the Cancer Patient Experience Survey 2013/14, performance at the trust was within the top 20% of trusts in answers to three questions, and in within the bottom 20% of trusts for two questions. The trust performed about the same as other trusts for the remaining 29 questions.
- The questions for which the trust performed in the top 20% of trusts were:

  Patient given the name of the community nurse specialist (CNS) in charge of their care (92% of those surveyed answered yes).

  Patient's rating of care 'excellent'/'very good' (90%).

  Hospital staff gave information about support groups (90%).
- The questions for which the trust performed in the bottom 20% of trusts were: 'always / nearly always enough nurses on duty' and 'hospital staff did everything to help control pain all of the time'.
- Staff were observed delivering compassionate care on all wards, and responding to patients' needs.
- In all ward areas staff pulled curtains around each patient's bay and closing 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.

Understanding and involvement of patients and those close to them

- The trust performed about the same as other trusts for all but one of the questions of the 2014 CQC inpatient survey.
- We were advised that family or carers could stay with patients who were nursed in a side room and that visiting times were flexible.

- 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 the patient, family (carers) and MDT met together to look at diagnosis, plan of care and discharge requirements.
- 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.
- 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.

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.
- The hospital chaplain described the excellent support and individualised care a woman received following a miscarriage.
- A specialist, midwife-led 'birth reflections' clinic was provided to support women who wanted to come to terms with their birth experiences.
- 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.

Summary of findings

Are services at this trust responsive?

Requires improvement

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

- The trust was not meeting referral to treatment times in a number of specialties.
- The ambulatory care service on the acute medical unit 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.
- Discharge arrangements and plans were not always clear across all medical wards.
- 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 trust's escalation policy meant that adolescents were moved from Cringleford ward to Buxton ward in times of high capacity pressures. This meant that patients' care and transition experiences were disrupted.

However:

- There was an excellent primary percutaneous coronary intervention (PPCI) service for patients with cardiac symptoms.
- Collaboration took place between nursing and medical staff to ensure a smooth discharge process for patients. In some areas, such as trauma and orthopaedics, there was nurse led discharge but this was not consistent across all services.
- 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. At both Norwich and Cromer sites.
- Staff across the whole service were aware of the complaints process and received feedback and learning.
- 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. Holt ward had refurbished a room to 1950's décor.

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).

- There were plans in place for a purpose built centre for endoscopy being progressed in conjunction with a number of partners.
- Surgical services were responsive to patients' needs by opening up to weekend working. An additional Vanguard theatre was in the process of being installed during the inspection. This unit, situated 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.
- 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 hospital at Cromer was underutilised and staff felt that more could be undertaken at the site to assist with referral to treatment (RTT) backlogs. Outpatient clinics at Cromer were not being back filled when consultants were on annual leave or on call.
- Effective team work was demonstrated in one-stop clinics at both the Cromer and Norwich sites for cataract surgery, urology, dermatology and cardiology outpatient clinics. Five urology consultants attend the Cromer hospital every fortnight to support the two week wait. This meant that patients could be seen and treated in one appointment to improve patient experience and reduce delays.

Access and flow

- This trust failed the referral to treatment (RTT) standard for non-admitted patients for the majority of months between July 2014 and May 2015, apart from October 2014 and May 2015. Performance was below the national average for the almost all of the period between April 2013 and May 2015, except for October 2014 when performance was above both the standard and the England average.
- In quarter 4 of 2014/15, 97% of cancer patients were seen by a specialist within two weeks of an urgent GP referral, which is

above the operational standard of 93%. The proportion of patients waiting less than 31 days from diagnosis to first definitive treatment was 73% during the same period, 74% of cancer patients waited less than 62 days from urgent GP referral to first definitive treatment, which was below the standard of 85%.

- 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 staff 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 colposcopy 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 the acute medical unit, male (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. 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 trollies 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.

- Collaboration took place between nursing and medical staff to ensure a smooth discharge process for patients. In some areas, such as trauma and orthopaedics, there was nurse led discharge but this was not consistent across all services. Discharge arrangements and plans were not always clear across all medical wards.
- 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. According to the most recent data from July 2015 to September 2015, this number had reduced further to 26 procedures which indicated an improving picture.
- The proportion of elective operations that were cancelled was similar to the England average, at around 1% in April to June 2015.
- 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.
- 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 and capacity (lack of birthing rooms).
- 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 and it was not on any risk register.
- The lack of capacity within the 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.

Meeting people's individual needs

- The trust performed amongst the worst 20% of trusts in England for call button response times.

- 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.
- 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.
- On Earsham ward we noted that there was a different sounding call bell to alert staff to the needs of patients with complex needs.
- Staff within the critical care complex 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.
- The trust had robust policies and processes to ensure people with patients with learning disabilities are identified.
- There were nurse specialists in place for patients with learning disabilities. These nurses were well known to staff in the trust and used to support patients.
- 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.
- There was an excellent service performed by volunteers based within the gynaecology outpatients 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.
- Staff were aware of the availability of translation services.
- 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. 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.

Dementia

- There were robust policies and processes to ensure people living with dementia were identified.

Summary of findings

- There was a healthcare professional lead in place for dementia who supported patients.
- 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 were assessed for their level of delirium by staff using the Confusion Assessment Method (CAM) and the Richmond Agitation Sedation Scale (RASS). An internal audit, within the critical care service, 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.
- 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 impartment to reminisce and engage in activities such as dominos or listen to music.
- A number of wards had photographic scenes placed within the ward, which could trigger memory to patients living with dementia or cognitive impairment.

Learning from complaints and concerns

- In 2014/15, this trust received 1,080 complaints, a rate of around three per 1,000 bed days. The average timeframe to process closed complaints was 29 working days.
- 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. Written complaints were managed centrally but ward managers and matrons stated that they were involved in the review of these complaints.

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.

Are services at this trust well-led?

Requires improvement

The leadership at a trust wide level has been rated as 'requires improvement' because:

- Due to the recent appointment of the senior leadership team the style of management requires embedding into the organisation.
- We are aware that a new governance structure is due to be in shadow form from January 2016 and in place by April 2016. The

current structure is known to not fully meet the needs of the organisation. Governance of issues such as security of children, checks of resuscitation equipment and controlled drug checks was not robust.

- Whilst the overall trust had a vision and values the strategy at a local level was less well developed. Therefore staff could not see how their work linked to the overall trusts strategy.
- 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 a lack of pace to respond to certain concerns. Mattishall ward and medical staffing at the Henderson unit had been raised previously but remained areas for concern.
- 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 Cromer hospital did not feel part of the overall trust and spoke of a disconnect between the location and the main trust site.
- The process to support staff providing care to mentally unwell children was not robust. Despite an escalation process to the executive team being in place we saw one child did not receive appropriate mental health support as most staff had limited mental health competencies.
- There was a lack of coherence around the links between divisional executive leadership and senior staff both within the critical care complex and the palliative care teams. There was a disconnect between senior management locally and the trust senior management. 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.

However we also saw that:

- The new chief executive was responsive to the concerns of staff. He had commenced engagement strategies to ensure that staff were well informed.

- The previous bullying culture had begun to dissipate and staff were aware of the change of the culture of the hospital.
- The consultant body were a cohesive team and loyal to the hospital and the senior management team.
- The executive team were responsive to issues highlighted during our inspection with immediate action being taken to address issues raised.

Vision and strategy

- 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.
- Local directorate strategies were less well developed and staff did not understand what part their directorate played in achieving the trusts vision and strategy.
- The development of the ED, with regard to physical layout, that had been previously shared with staff was under review by the executive team.
- 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.
- There was a disconnect between the SPCT and the executive directors regarding staffing establishment to provide a seven day service. Six business cases for increased staffing had been refused on the grounds of funding. The executive team believed that a seven-day service could be achievable based on current staffing, however, the SPCT did not.
- There was a business continuity policy in place for Cromer hospital which had not yet been ratified. It included topics such as the utilities for the hospital but did not include all aspects of continued sustainability at the site.

Governance, risk management and quality measurement

- A review of Governance and Assurance structure paper went to the board for approval in September 2015 outlying the revised structure in response to a number of recommendations from our last report and from the independent PwC report. Two objectives were outlined, to enhance non-executive challenge

and create additional capacity within the governance structure by creating a quality and safety committee and finance and investments committee. All committees' terms of reference were updated with a non-executive membership included.

- Team meeting route of escalation is through directorate / divisional integrated governance meetings which then escalate and report to the sub boards in the relevant committee up to divisional board. It had been recognised that this was too unwieldy and ownership of sub boards was being focused back to the divisions.
- Documentation from all meetings was not consistent. A template for directorate and divisional governance meetings had been developed but the usage varied. Divisional directors were attempting to encourage the use of the templates at directorate level.
- 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 was produced to reduce the risk of reoccurrence. However the follow up 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 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 patents 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.

- There was a regular division quality dashboard outlining main quality indicators including infection rates, serious incidents, number of new risks, and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (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.
- There was a lack of pace to respond to certain concerns; Mattishall ward and medical staffing had been raised previously but remained areas for concern. 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. On-site medical support at the Henderson unit was minimal and had been raised as a concern from our previous inspection in March 2015 yet arrangements remained the same and there was no evidence that this had been reviewed.
- Governance of issues, such as security of children within Lion ward and the children's day ward, 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.
- 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.
- 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.
- The risk register for Cromer was included as part of the trust's overall risk register,

Summary of findings

Management and oversight of risks needed to improve. Review dates for risk assessments for control of substances hazardous to health (COSHH) were outstanding, with one last reviewed May 2012.

Leadership of the trust

- 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 terms of reference for the Board had been updated to reflect the increase in the Board's membership and to include the creation of the COO post.
- There were proposed changes of the divisional structure underway at the time of inspection. The proposed structure is a clinically led model comprising of four divisions with a triumvirate under each comprised of a medical, nursing and service manager. Divisional nurse director roles were new to provide a stronger nurse input. In order to support these new roles the director of workforce was leading on a clear development programme to ensure training and support was in place.
- During the responsive inspection in March it was identified that there were significant divisions within the executive and senior leadership teams. The previous discord had created a feeling of instability within the trust and this meant that there had been no clear direction and leadership approach. Whilst new appointments had initiated a more unified direction this was still in its infancy. The team were learning to work together and build a team working dynamic but these relationships were not yet well established.
- There was a large experienced site management team that expressed since the introduction of the chief operating officer they had felt more accepted as part of the hospital team. The COO had given the team a voice and they stated they were able to make decisions and give direction at the bed meetings which were referred to as "tactical meetings".
- The site management team did not attend divisional meetings however the site managers attended the monthly matrons and safeguarding meetings, weekly senior nurse meeting on a Monday and senior matrons meeting on a Friday. However the team stated that the weekly meetings were not minuted or recorded which meant that there was no assurance that any ongoing issues were resolved or dealt with in a timely manner.
- There was a disconnect between the consultant clinicians and the nursing staff within the emergency department. There were issues raised on site that the executive team were swift to deal

with. At the unannounced inspection on 25 November 2015, senior nursing staff were hopeful for improvement as there been some more positive interactions and engagement with the consultant body.

- Staff felt well supported by their local manager but reported that they did not see the senior management team in ward and frontline areas.
- 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. 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.
- There was minimal support for the safeguarding lead from the senior team. The lead nurse had made an excellent start since being in post, July 2015, and was already well respected. They had clear focus and direction for improvement but would need the support from the senior nursing team and executive team in order to improve safety within the trust.
- 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.
- 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.

Culture within the trust

- There were 6,930 staff working in this trust of which around 10% were from black, minority and ethnic cultures. There was an average staff turnover rate of 10% across the trust in 2014/15. Staff sickness levels in this trust were 5% in January 2015.
- At our previous inspection we found that there was bullying culture which was alleged to have been present within the trust. At this inspection we spoke with all grades of staff about the impact that the new senior team had had on this. We found that staff recognised the previous culture and found that this was beginning to change. The senior management team had taken action to ensure that staff felt able to raise concerns with them or their immediate line managers. Most staff stated that they felt able to approach the senior team. Whilst we were

inspecting a member of staff emailed the chief executive who responded promptly to their concerns. This provided reassurance to the member of staff that they could raise issues in an open culture.

- Whilst most staff reported an improving culture we were given instances where the previous culture remained. This appeared to be at an operational level and was often caused by capacity issues for the trust. Staff felt bullied into taking patients who were not suitable for their area.
- Staff in the critical care complex and in the specialist palliative care teams felt that there was a disconnect between their teams and the senior management team and Gateley ward was identified where staff turnover was higher and a number of investigations had been undertaken following concerns from staff.
- Radiology staff raised concern about reputed 'rivalry' between radiology and cardiology staff, particularly in relation to use of available clinic space for outpatient appointments. We received reports of bullying and harassment behaviour within the radiology department on the Norwich site due to unclear definitions of roles and responsibilities.

Fit and Proper Persons

- The trust had taken steps to ensure effective arrangements were in place to ensure that all directors, or those performing the functions of a director, were fit and proper in line with regulation 5 of the Health and Social Care Act Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- We reviewed five records from the most recently appointed senior team and found that all had a Fit and Proper Persons Regulation (FPPR) recruitment and personal file checklist completed retrospectively which had been signed and dated.
- Evidence of the interview and assessment process was lacking in the five records reviewed. In three out of the five cases references were not in the personal file, two out of the five had no evidence of right to work checks; three had no evidence of interview date or induction. The checklist introduced as part of the policy would address these gaps for future appointments.
- A Fit and Proper Persons (Directors) policy had been developed and approved at Board on 23 October 2015. The policy outlined the requirements for FPPR and duties and responsibilities under the policy. On an annual basis existing staff are required

to complete a self-declaration, checks to be made against insolvency and bankruptcy registers and register of disqualified directors and all to participate in annual appraisal to ensure ongoing compliance.

Public 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 hold an Organ Donation Committee meeting quarterly, chaired by the DON. The committee includes families, service users, mortuary staff, chaplaincy and NHSBT staff. The committee discuss aspects of, and ways of improving, end of life care for transplant patients.
- 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.

Staff engagement

- The trust performed in the top 20% of trusts for four questions, and in the bottom 20% of trusts for 11 questions in the 2014 NHS Staff Survey. For the remaining 16 questions, the trust performed similar to other trusts. The response rate in this trust was 45%, compared to a national average response rate of 42%.
- The chief executive had undertaken staff engagement monthly "Viewpoint" sessions with staff in order that they were kept informed and were able to ask any questions of him. Some staff were aware of this initiative.
- Staff at Cromer stated that communication from the Norwich site at times was slow and could be improved.
- 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'. Senior managers of the service described the MSLC as having a positive and proactive influence on the care of women.
- There was a project underway to change the focus of annual appraisals to be based on trust values in 2016. This has been implemented as part of the trust's strategy to demonstrate staff engagement and an understanding of how their role fits into the trust wide strategy and objectives.

- The consultant body in general were cohesive and loyal to the trust. They recognised a significant shift in the way in which the trust now operated and felt engaged.
- 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.

Innovation, improvement and sustainability

- The trust had pledged to work collaboratively with other local providers to rebalance acute care and address issues that were system wide. Terms were being discussed between three other trusts and community services. This would be new and not territorial and the chief executive and chair were very optimistic and keen to drive this forward.
- 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.
- The trust had recently started training four Physician's Assistants (Anaesthesia) (PAAs). 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.

Overview of ratings

Our ratings for Norfolk and Norwich University Hospitals NHS Foundation Trust

	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

Our ratings for Norfolk and Norwich University Hospitals NHS Foundation Trust

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

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. 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 trust MUST take to improve

Action the trust 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.

Outstanding practice and areas for improvement

- 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.
- 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.

This section is primarily information for the provider

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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1)(2)(a)(b)(c)(d)(g)(h) 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. 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. 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. 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

This section is primarily information for the provider

Requirement notices

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 provided high dependency or emergency care to children outside of the resuscitation department.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 (1)(2)(c)** 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.