Norfolk and Norwich University Hospitals NHS Foundation Trust

Norfolk and Norwich University Hospital

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Norfolk and Norwich University Hospital

Requires Improvement 

The Norfolk and Norwich University Hospital (NNUH) is a 1,200-bed teaching hospital. Medical care services provided by NNUH include the specialties of cardiology, respiratory medicine, gastroenterology, endocrinology, stroke, neurology, rheumatology, haematology, oncology, renal medicine, older people's medicine, radiotherapy, palliative care and diabetes.

Medical care had 95,392 admissions between March 2021 and February 2022, including 28,488 emergency admissions. The specialties with the highest number of admissions were gastroenterology (23,202), clinical oncology (21,120), and general medicine (13,551).

We last inspected the service in February 2022 as part of a review of urgent and emergency care services in Norfolk and Waveney. No ratings were attached to this inspection.

We carried out this unannounced focused inspection because we received information giving us concerns about the safety and quality of the services of medical care and older people's services. The information of concern related to nurse and healthcare assistant staffing shortages and the use of additional beds in bays impacting on patient care.

As this was a focused inspection, we only inspected parts of our five key questions. We inspected parts of safe, effective, caring, responsive, and well-led.

We did not inspect all the core services provided by the trust as this was a risk-based inspection. We continue to monitor all services as part of our ongoing engagement and will re-inspect them as appropriate.

The ratings for safe and effective were limited to requires improvement as we issued requirement notices. We did not rate responsive and well-led at this inspection as we only inspected part of the key question. We rated caring as good.

See the medical care (including older people's services) section for what we found.

How we carried out the inspection

The inspection team comprised of a lead CQC inspector, an inspection manager, 1 other CQC inspector and an expert by experience.

During the inspection we spoke with 21 members of staff and carried off site interviews with the divisional leadership team, the trust falls lead, the lead matron for discharge and the operations director for urgent and emergency care. We spoke with 15 patients and relatives or carers. We observed care provided; attended site and staffing meetings, reviewed relevant policies and documents and reviewed 6 patient records.

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

Medical care (including older people's care)

Requires Improvement 

We rated the service as requires improvement because:

- Despite a range of recruitment initiatives, the service did not have enough nursing and healthcare assistant staff and we found that this was impacting on patient care. Staffing shortages were impacting on the ability of staff to assess and respond to patient risk, and their ability to effectively manage patients' nutritional, hydration and pain relief needs. Staff were not always able to ensure that intentional rounding was being completed and recorded as required. Morale amongst staff was low. Staff reported feeling exhausted and stressed.
- Arrangements to admit, treat and discharge patients were impacted due to significant numbers of patients that no longer met the criteria to reside in the hospital but were unable to leave as they were waiting for access to onward care packages. This had led to a practice of adding additional beds into bays in December 2021. This was initially intended as a temporary measure but had continued throughout 2022. The use of additional beds in bays was impacting on the space available to provide care and on privacy and dignity for patients. Challenges with flow had also led to the service moving patients between clinical areas when there was not a clear medical reason or when it was not in their best interest.

However:

- The service controlled infection risk well.
- Staff worked well together for the benefit of patients. The trust was actively engaging with other agencies in Norfolk and Waveney to address the challenges with flow through the system. Staff were pushing for this work to be carried out at a more urgent pace and to encourage risk to be shared more equally by all system partners.
- Staff treated patients with compassion and kindness, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- Leaders ran services well using systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. The culture was centred on the needs and experience of people who used services and encouraged openness and honesty at all levels within the organisation. All staff were committed to continually learning and improving services.

Is the service safe?

Requires Improvement 

Cleanliness, infection control and hygiene

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

Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. However, the use of additional beds in bays created a more cluttered environment which made it more challenging for cleaning staff to access and clean all areas.

Medical care (including older people's care)

The service generally performed well for cleanliness. Each ward was required to carry out at least 4 infection control audits per month. We reviewed the last 3 months of audit results as part of our inspection and these showed a high level of compliance.

The cleaning records we reviewed during our inspection were up-to-date and demonstrated that the areas we visited were cleaned regularly.

The service mostly ensured that patients were screened for infection as required. The service screened new admissions for methicillin-resistant Staphylococcus aureus (MRSA). Non-elective screening compliance was high but had deteriorated from 92.1% in May 2022 to 85% in October 2022. In August 2022, asymptomatic screening for Covid-19 had ceased, except for patients on the oncology ward. Symptomatic patients continued to be tested.

Staff followed infection control principles including the use of personal protective equipment (PPE). PPE including face masks, gloves and aprons were available in all areas we visited. We saw staff wearing the correct PPE and all clinical staff were bare below the elbows. We observed staff washing their hands before and after delivering care.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed that 'I am clean' stickers were used in all of the areas visited during our inspection.

Environment and equipment

The use of additional beds in bays was impacting on the space available to provide care and on privacy and dignity for patients. Patients could not always reach call bells and staff were not always able to respond quickly when called. Staff did not always carry out daily safety checks of specialist equipment.

Patients could not always reach call bells and staff were not always able to respond quickly when called. We observed 16 patients who did not have a call bell in reach during our inspection. However, most patients said that staff regularly checked on their wellbeing and that they had not experienced significant delays in being able to request support from staff when required. The use of additional beds in bays and corridors meant that there were not enough call bells for all patients. However, patients in additional beds were given access to a battery powered button, which acted as a call bell. This device looked visibly different to a standard call bell and we spoke to 2 patients who did not understand what the device was for. These patients would therefore not have known to use the device to request support from staff. Staff said that staffing shortages were leading to delays in their ability to respond to call bells in a timely manner. However, we did not observe significant delays in call bell response times during our inspection. This has been reported on further under the caring domain.

The design of the environment did not always follow national guidance due to the use of additional beds in bays. This meant that there was insufficient space between beds. This was impacting on the space available for staff to provide care to patients. Staff raised concerns that there was insufficient space to safely resuscitate patients and provided examples of recent incidents which had demonstrated this. When a patient required resuscitation, staff were required to move beds and surplus equipment from the bay to provide space and they would use screens for privacy. The cardiac arrest team had been streamlined to the minimum required, to reduce the amount of staff at the cardiac arrest. The trust had identified and assessed the risk relating to the resuscitation of patients when the use of additional beds in bays was introduced in December 2022. The risk had subsequently been added to the risk register.

The use of additional beds in bays meant that each bed space did not have dedicated oxygen and suction ports. The trust had put actions in place to mitigate this risk, including the use of portable oxygen and suction when necessary.

Medical care (including older people's care)

The trust's electronic ward view system had been updated to ensure that patients in escalation beds were clearly identified.

The trust had held workshops with staff to discuss the practical implications of the use of additional beds in bays, including manual handling and equipment considerations.

Where patients were cared for in additional beds in bays and corridors, the hospital had a policy in place for using these bed spaces and clear guidance for staff to follow. Staff assessed patients following set criteria to determine whether they were well enough to be cared for in these areas. However, staff raised concerns that whilst some patients may meet this criteria, their individual circumstances meant that they remained inappropriate to be cared for in these areas. For example, patients who were incontinent would not be able to be cared for with privacy and dignity in a corridor. During our inspection we observed a frail and elderly patient was visibly upset after being cared for in the corridor for over 7 hours. Other patients on the ward raised concerns about this and offered to swap places with the patient. Staff were in the process of making arrangements for the patient to be moved into a bay.

The use of additional beds in bays also meant that there was not enough space for a chair beside the bed. Whilst staff stated that an additional chair could be placed at the end of a patient's bed, almost all of the patients that we observed during our inspection remained in bed during the day. The lack of space also impacted on patients' ability to mobilise and to use mobility aids. Leaders had recognised that the use of additional beds in bays led to an increased risk of patient deconditioning and a risk had been added to the risk register relating to this. The service had introduced a range of initiatives to mitigate this risk. For example, sports therapists from an external organisation came onto older people's medicine wards to work with patients on a daily basis. Volunteers assisted physiotherapists with bed and chair exercises once a week. The trust had also opened a ward to accommodate medically optimised patients, to support patients with rehabilitation to enable them to return home.

Staff did not always carry out daily safety checks of specialist equipment. On Earsham and Kimberley wards we found that whilst weekly checks of resuscitation trolleys had been completed, there were gaps in daily checks being carried out as required. On Earsham ward there were more than 20 entries vacant since May 2022 and on Kimberley ward, daily checks had not been completed on 5 days out of 31 days.

A daily safety audit was completed by ward areas to ensure that basic standards were being maintained whilst escalation beds were in use. For example, the audit included checks to ensure that resuscitation trolley checks had been carried out as required. We reviewed the audit results as part of our inspection and these demonstrated a high level of compliance. There was an average compliance level of 94.44% between August and October 2022. However, this audit had not identified the concerns that we identified during our inspection regarding the completion of daily safety checks of resuscitation equipment.

Assessing and responding to patient risk

Staff did not always update risk assessments for each patient as required. Patients' physiological observations were not always being reassessed and recorded as frequently as required.

Staff used a nationally recognised tool to identify deteriorating patients. The service used the National Early Warning Score (NEWS2) system. Observations were recorded electronically and patients with a raised NEWS2 score were flagged on the electronic 'ward view' dashboard. This meant that senior clinicians were readily aware of deteriorating patients.

Patients' physiological observations were not always being reassessed and recorded as frequently as required. We reviewed 6 patient observation charts as part of our inspection and there were delays in the completion of observations

in all 6 records. In 2 of the records we reviewed, these delays had occurred at a time when the patient required escalation due to a raised NEWS2 score. There were 36 occasions where 4 hourly observations were delayed. The delay in the completion of these observations was an average of 3.5 hours. There were 7 occasions where 1 hourly observations were delayed. The delay in the completion of these observations was an average of 2.9 hours. This meant that there was a risk that there would be delays in the identification and escalation of deteriorating patients. Whilst we did not identify evidence of harm to patients in the records that we reviewed as part of our inspection, we did find evidence of this through a review of incidents that had been reported in the medical division in 2022. For example, an incident had occurred on Mulbarton ward in May 2022. The investigation found that the patient was on 1 hourly observations but the completion of these observations was delayed by 2 hours. When the patient was next checked, they were found unresponsive. The patient subsequently passed away. The investigation found the root cause of the incident to be "Failure to recognise and escalate a deteriorating patient via the NEWS2 Early Warning Score tool."

Staff carried out monthly audits to monitor patient observation and escalation. Each ward was required to carry out 20 audits per month. We reviewed the results from the audits carried out in the 3 months prior to our inspection. These showed that overall compliance during this period was 87.24%. The October 2022 audit showed that patient's physiological observations and NEWS2 score been reassessed and recorded at the required frequency in 98.1% of cases. This did not align with our findings on inspection and raised concerns that the audits were providing leaders with false assurance of compliance.

Following our inspection, we asked the trust to provide further information about the action they were taking to ensure that patients' physiological observations and NEWS2 scores were reassessed and recorded at the required frequency. The information provided by the trust stated that changes were being made to electronic dashboards to improve the ability of staff to identify patients who were overdue for observations. A quality improvement project relating to the identification and escalation of deteriorating patients was due to commence in January 2023.

Staff did not always ensure that risk assessments were reviewed as frequently as was required by the trust policy. For example, trust policy stated that falls, pressure ulcer and malnutrition risk assessments should be reviewed at minimum on a weekly basis. There were delays in either the initial assessment of risk or the reassessment of risk in 5 out of 6 records reviewed as part of our inspection. However, there was no evidence in the patients' clinical records to indicate that the patients' level of risk had changed or any evidence that the delay in reassessing risk impacted the patients' condition or treatment.

The trust had implemented a new falls policy in April 2022 and a new multifactorial falls risk assessment was implemented at the end of October 2022. Our review of 6 patient records showed that the new falls risk assessment document was not consistently being fully completed. We also found that staff were continuing to use the old falls risk assessment document alongside the new risk assessment document. The trust's falls lead was aware of this concern and was working with wards to improve compliance.

Our review of records also showed that there were gaps in the completion of daily nursing assessments. The daily nursing assessments ensured that nursing staff carried out a daily review of a patient's needs and areas of risk, including nutrition, mobility, tissue viability, pain, and mental state. Gaps in the completion of the daily assessments were identified in 4 out of 6 records reviewed.

The trust had linked pressure ulcer incidents to the use of escalation beds and to staffing shortages. For example, in the August 2022 board papers, the trust stated "The rise in (grade 3) pressure ulcer incidents has been related to the rise in admission numbers, increased inpatient numbers in bays and non-bay areas, and patients who are in an increasingly frail state on admission, with decreased CHPPD (care hours per patient day) impacting on timely delivery of care." The

trust had also linked falls incidents to staffing shortages and the use of escalation beds. For example, this included a thematic review of 7 inpatient falls within the medicine division, which was carried out in August 2022. The investigation report stated "The impact of reduced staffing levels was significant in all 7 incidents." However, data provided by the trust showed that in the medicine division, the overall number of pressure ulcers had remained steady in 2022 and the overall number of falls was on a downward trend during the same period.

Staff carried out monthly audits to monitor compliance with the processes in place for the prevention and management of pressure ulcers and falls. Each ward was required to carry out 20 audits per month. We reviewed the results from the audits carried out in the 3 months prior to our inspection. These showed that overall compliance during this period was 81.51% for pressure ulcer prevention and care. Compliance levels in pressure ulcer prevention and care audits had improved from 75.25% in August 2022 to 85.1% in October 2022. Overall compliance levels for falls audits in the 3 months prior to our inspection was 79.65%. Compliance levels had fallen from 88.17% in August 2022 to 68.58% in October 2022. The lowest scoring questions in October 2022 related to staff carrying out a post-falls hot debrief (54.5%) and ensuring that part 2 of the new falls risk assessment was completed as required (62.9%). The trust's falls lead was continuing to work with ward areas to address the areas of concern identified through audits.

Staff were carrying out quality improvement work relating to falls. We observed some of the new falls initiatives in practice during our inspection. For example, patients at high risk of falls were given a yellow blanket and yellow socks, to ensure that they were easily identifiable to staff. Staff used a 'baywatch' initiative to ensure that patients at high risk of falls could be closely monitored, despite staffing shortages. Patients at high risk of falls were placed together in the same bay and a member of staff remained in the bay at all times to monitor patients. A falls response team had been set up by the trust's falls lead for any patients who had more than one fall, to review the care being provided and consider whether any additional measures should be implemented.

Staff shared key information to keep patients safe when handing over their care to others.Shift changes and handovers included all necessary key information to keep patients safe. This was confirmed through our observations of two nursing handovers and a safety huddle during our inspection.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

Nurse staffing

The service did not have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and made adjustments where possible.

The service did not have enough nursing and support staff to provide the right care and treatment. Shortages in nursing and healthcare assistant staffing levels meant that staff were often overstretched. All staff we spoke with expressed concern about the impact of staffing shortages on patient care. For example, one member of staff stated "I'm not able to give the care that I want to." Staff provided examples of delays in the provision of personal care, delays in responding to call bells, delays in the provision of pain relief, delays in measuring and recording patients' physiological observations, delays in repositioning patients, and delays in their ability to support patients at mealtimes. Staff also said that they were not always able to provide 1 to 1 observation of patients who were at high risk of falls or patients who were at risk of absconding from the ward when subject to a Deprivation of Liberty Safeguards (DoLS). Our review of patient records supported some of the concerns raised by staff and this has been reported on further under assessing and responding to

risk. The trust performed worse than expected in the NHS Adult Inpatient Survey 2021 for the question 'In your opinion, were there enough nurses on duty to care for you in hospital?'. However, most of the patients that we spoke with during our inspection did not feel that they had experienced significant delays in the provision of their care. In addition, we did not observe significant delays to patient care during our inspection.

The number of nurses and healthcare assistants did not match the planned numbers. On the day of our inspection none of the areas we visited had the planned number of nursing or healthcare assistant staff. Data provided by the trust showed that in October 2022, shift fill rates were 71.5% for healthcare assistants and 83.5% for registered nurses. There were 1523 staffing red flags raised in the medicine division in October 2022. This was an increase from 1273 in August 2022. Staffing red flags are reportable events that indicate the need for an urgent review of staffing levels, skill mix, patient acuity and dependency. The data showed that 90% of staffing red flags raised in October 2022 remained open. This means that the staffing risk had not been mitigated or that an update had not been recorded. Care hours per patient day (CHPPD) in the medicine division were 5.5 in October 2022. Care hours per patient day (CHPPD) is calculated by adding together the hours of registered and unregistered staff and dividing the total number of patients in beds at midnight. There is no nationally set figure for CHPPD. However, the peer median based on trust size was 8.3 CHPPD.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Staffing meetings were held twice a day to review staffing levels on each ward and to move staff to areas that were short staffed as required and where possible.

The ward manager could adjust staffing levels daily according to the needs of patients. However, staff told us that additional staff were not always provided as there were no staff available to fill the gaps in the shift allocation. We saw this in practice during our inspection. Information provided by the trust showed that staff from the medicine division had been redeployed to work in other areas on 394 occasions in August 2022. This was a reduction from 563 occasions in January 2022. The medicine division had introduced a 'sister wards' initiative for the movement of staff. Leaders would try to redeploy staff within the sister ward areas so that staff would develop some familiarity with the other teams and specialty.

The service had high vacancy rates. The overall vacancy rate for registered nurses was 16.9% at the time of our inspection in November 2022. This was a slight increase from our last inspection in February 2022. However, the vacancy rate for band 5 (newly qualified or staff nurse) registered nurses was higher, at 25.5%. Vacancy rates for healthcare assistants were 25%. This was an improvement from our last inspection in February 2022, when vacancy rates were 28%.

The service had increasing turnover rates, which were higher than the trust target. The annual turnover rate was 14.5% for nursing staff and 27% for healthcare assistant staff, compared to the trust target of 10%. The medicine division had implemented a wide range of measures to improve staff retention. This included study days for staff, expansion of supportive roles (including an international nurse support and newly qualified nurse support), and the establishment of band 3 healthcare assistant roles.

The service had sickness rates which were higher than the trust target. Sickness rates in the medicine division were 6.4% for nursing staff and 10.3% for healthcare assistant staff, which was above the trust target of 3.9%. Anxiety, stress and depression accounted for 30.8% of the reasons for absence in October 2022. The trust had implemented a range of wellbeing measures to support staff. These have been reported on further under the well-led domain.

The service utilised bank and agency nurses used on the wards. At the time of our inspection, the medicine division utilised 10.2% bank staffing and 3.5% agency staffing. This included both nurses and healthcare assistants. The service had introduced the use of bank and agency healthcare assistants in 2022.

Medical care (including older people's care)

The trust had a number of recruitment initiatives in place for registered nurses and health care assistants. This included the recruitment of international nurses and newly qualified nurses. The trust also carried out large scale recruitment events for healthcare assistants.

The trust was in the process of carrying out a review of nurse staffing establishment levels at the time of our inspection.

The medicine division had implemented a 'check and confirm' process where senior nurses carried out a detailed review of staffing rosters. Information provided by the trust showed that this had led to a reduction in unfilled duties.

Is the service effective?

Requires Improvement 

Nutrition and hydration

Staff were not always able to give patients timely support to eat. Drinks were not always in reach. Staff used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff were not always able to ensure that patients had timely support to eat. Staff said that staffing shortages were leading to delays in being able to support patients at mealtimes. For example, one member of staff said that patients were "either not getting support at all or when they do, the food is cold". We observed that 2 patients, who required support during mealtimes, had their tray of food placed next to them but they were not receiving support to eat and they were asleep. We observed 2 other patients who required support during mealtimes who were experiencing some delays in receiving their meals. However, all other patients observed during our inspection were receiving appropriate and timely support during mealtimes. We observed that additional staff from other areas of the hospital came onto the wards during mealtimes to provide support for patients who required it. Nurses identified patients who required extra support during handover.

Drinks were not always in reach. We observed that 11 patients did not have drinks within reach during our inspection. However, we observed other patients who were receiving support from staff to drink when required.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. However, staff had not always been able to ensure that the risk of malnutrition was initially assessed and re-assessed on a weekly basis in line with the trust's policy. We identified delays in the initial assessment or re-assessment of the risk of malnutrition in 3 out of the 6 patient records reviewed during our inspection. However, all of these patients were at low risk of malnutrition and there was no indication in their clinical record that there had been a change in their nutritional status.

Staff did not always fully and accurately complete patients' fluid and nutrition charts where needed. In 2 of the patient records we reviewed, staff had dated food and drink charts but no other information had been completed to show whether any food had been offered or consumed.

Managers monitored how effectively staff were identifying, monitoring and meeting people's nutritional and hydration needs through monthly audits. Each ward was required to carry out 20 audits per month. We reviewed audits from the last 3 months as part of our inspection. Overall compliance was an average of 88.39% during this period.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Nurses identified patients who had been referred for specialist support during handover.

The service was carrying out quality improvement projects relating to nutrition and hydration. This included the development of a team of ward-based nutrition champions and the introduction of meal service co-ordinators to oversee mealtimes.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. However, staff were not always able to ensure that pain relief was provided in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. We observed staff checking on patients' pain levels and asking whether they required pain relief.

Staff were not always able to ensure that pain relief was provided in a timely way. Staff said that staffing shortages were leading to delays in the administration of pain relief. We found delays in the administration of pain relief in the 2 out of the 6 medication charts that we reviewed as part of our inspection. However, the majority of patients said that staff regularly checked on their pain levels and provided pain relief soon after they requested it.

Staff prescribed, administered and recorded pain relief accurately. This was confirmed through our observations on inspection and a review of 6 medication charts.

Nurses ensured that any relevant information about patients' pain levels and pain relief requirements were shared during handover.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. For example, each ward held twice daily multidisciplinary red to green meetings to discuss the patients on the ward. Red to green is a discharge initiative which is used to reduce internal and external delays. The meetings were attended by members of the discharge team as well as nursing and medical staff from the ward.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff regularly worked with other agencies in the Norfolk and Waveney system to facilitate discharge and address any challenges with flow through the system. Nursing staff were limited on the time that they had available to make discharge arrangements due to staffing shortages. However, each ward had a discharge coordinator who supported staff to communicate with other agencies regarding discharge arrangements.

Staff noted that the level of engagement from other agencies had significantly improved in 2022. However, staff said that they continued to experience some challenges when working with other agencies to make discharge arrangements. This included delays in receiving responses and difficulties in being able to access a senior decision maker.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. This was confirmed through our observations and our review of patient records during our inspection.

Medical care (including older people's care)

Patients had their care pathway reviewed by relevant consultants. Our review of patient records demonstrated timely consultant reviews of patients' care, with clear management plans in place. Patients that were being cared for outside of a specialty ward would be visited by their consultant on the ward where they were residing.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

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

Conversations with staff demonstrated that they put patients at the heart of everything they did. Staff were focused on providing the highest quality care possible, despite the challenges that they were facing. This was confirmed through our observations of care.

Patients said staff treated them well and with kindness. Whilst in some cases patients noted the impact of staffing shortages and the use of additional beds in bays, they also recognised that staff were doing their best to provide the highest quality care possible. Patients and relatives told us that "Staff are very kind...they really try", "I cannot praise the staff enough" and "staff are fabulous, they are lovely".

Staff took time to interact with patients and those close to them in a respectful and considerate way. For example, staff provided patients with an explanation of the care that they were about to provide. We observed staff asking patients how they would prefer personal care to be delivered. Patients were given the option to complete personal care themselves, where possible, and if this was their preference.

Staff tried to be discreet when caring for patients. However, this was not always possible. The use of additional beds in bays meant that there were not enough curtains to go around each bed. Portable screens were available for use when required. However, the screens did not provide the same level of privacy for patients as a curtain. This meant that patients may not always be fully protected from the view of passers-by, including during the provision of personal care. Staff hooked curtains over the top of screens to attempt to provide additional privacy for patients. None of the patients spoken with during our inspection felt that their privacy and dignity had been compromised. For example, one patient said that staff "completely respect my privacy, they always use screens".

Staff tried to ensure that patients were covered to protect their dignity. However, we observed 1 occasion where a patient's undergarments were exposed and a member of staff did not take action to cover the patient up. The patient remained uncovered for 10 minutes, until a different member of staff entered the bay and covered the patient up.

Staff tried to be responsive when caring for patients. However, staff said that this was not always possible due to staffing shortages, which were leading to delays in their ability to respond to call bells in a timely manner. Some patients said that they had experienced delays in staff responding to call bells, although in most cases these were not significant. The trust performed worse than expected in the NHS Adult Inpatient Survey 2021 for the question 'Were you able to get a member of staff to help you when you needed attention?' However, we observed staff responding to call bells in a timely manner during our inspection.

Medical care (including older people's care)

Most patients said that staff regularly checked on their wellbeing. However, our review of patient records showed that staff were not always able to ensure that intentional rounding was being completed as required. Intentional rounding requires nurses to undertake regular and standardised checks on individual patients at set intervals to assess and manage their fundamental care needs. We reviewed 6 patient records as part of our inspection and we identified delays in the completion of intentional rounding in 4 records.

In some cases, we observed that more able-bodied patients were recognising the pressures that staff were under and were taking on a caring role towards other patients. For example, one patient described how they had assisted other patients to the toilet and had assisted them to eat their meals. We observed another patient leaving their bay to locate a member of staff so that they could get a blanket for the patient in the bed next to them, who was cold.

Staff followed policy to keep patient care and treatment confidential. For example, nursing handovers and red to green meetings were carried out in private rooms away from clinical areas to ensure that discussions about patients could not be overheard.

Staff understood and respected the individual needs of each patient, including their personal, cultural, social and religious needs, and showed understanding and a non-judgemental attitude when caring for or discussing patients with mental health needs. This was confirmed through our observations and our discussions with staff and patients.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients provided positive feedback about the support provided by staff. For example, one patient stated “I was very nervous and anxious because I have never been in hospital before...staff were very good at calming my anxiety.”

Staff said that the use of additional beds in bays created challenges in helping patients to maintain their privacy and dignity when supported patients who became distressed in an open environment. Some patients said that they could overhear the conversations between other patients and staff due to their beds being in close proximity. For example, one patient said “they always use curtains around the bed but of course people can hear”.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. This was confirmed through conversations with staff and patients, and our observations of nursing handovers and red to green meetings.

Understanding and involvement of patients and those close to them

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

Staff mostly made sure patients and those close to them understood their care and treatment. Most patients said that staff kept them updated and explained their care and treatment to them. For example, one patient “staff always do their best to keep me informed about when I’m going home and speak to my son.” Another patient said that staff had provided a full explanation about the reason that they were being placed on new medication and what it was for. We observed staff providing updates to patients about their care during our inspection. However, 2 patients spoken with

during our inspection were unclear about the plans for their discharge. In addition, 2 relatives raised concerns about the lack of communication from staff to keep them updated about their relative's care. The trust had also identified a theme in complaints around communication with relatives. Leaders were in the process of recruiting into ward clerk vacancies to improve communication with relatives.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. For example, we observed a member of staff using paper and pen to aid their communication with a patient who was hard of hearing. Another patient was non-verbal but they communicated with staff using gestures.

Staff supported patients to make advanced decisions about their care. The patient records we reviewed during our inspection showed that where possible, patients and relatives had been involved in making advanced decisions about their care.

Patients and their families could give feedback on the service and their treatment. However, staff did not always have time to support them to do this. Response rates for the Friends and Family Test were just 2.9% in September 2022, compared to a national average of 19.2%. In the 2021 CQC inpatient survey, the trust performed worse than expected for the question 'During your hospital stay, were you ever asked to give your views on the quality of your care?'. The trust was implementing a range of actions to improve response rates, including volunteers visiting wards to gather feedback and carrying out post-discharge calls.

Patients gave positive feedback about the service. The trust's inpatient Friends and Family Test score was 96% positive in September 2022.

Is the service responsive?

Inspected but not rated

Access and flow

Arrangements to admit, treat and discharge patients were impacted due to significant numbers of patients that no longer met the criteria to reside in the hospital but were unable to leave as they were waiting for access to onward care packages. However, the trust was actively engaging with system partners to address these issues.

The hospital had significant capacity problems due to the availability of beds to admit patients. This was due to the high number of patients that were medically fit to leave the hospital but there was no care package immediately available to enable them to be discharged safely. Staff shortages and service quality has significantly reduced capacity across social care and learning disability services in Norfolk and Waveney. This had resulted in significant delays in transferring people from hospital to their own home or an appropriate place of care. This in turn meant people who were medically fit for discharge remained in hospital, delaying the admission of new patients.

The trust had an average of around 150 patients with no criteria to reside (NCTR, pathways 1 to 3) during the first half of 2022. However, in July 2022, 140 beds were closed in the community at short notice. This resulted in the trust gaining an extra 40 patients with NCTR every month until they reached a peak of 245 in September 2022. This had amounted to 6.5% of their bed base, or the equivalent of more than 5 wards. There had been a commitment to get 140 additional community beds back in Central Norfolk by the end of October 2022. However, only 39 beds had been reinstated at the time of our inspection in November 2022 and many of these were blocked. Staff said that there was improved executive level oversight of this issue and executives were working to raise this issue with system partners.

Medical care (including older people's care)

The number of patients with NCTR had begun to reduce back down at the time of our inspection. There were 150 patients with no criteria to reside on the day of our inspection. Most patients (86) were waiting for care pathway 2. This group of patients required transfer to a non-acute bed to receive rehabilitation and assessment until they could return home safely. There were also 42 patients on care pathway 1; this group of patients would return to their own home for an assessment and support for social care needs. Staff said that council assessments took a mean of 4 to 5 weeks to be completed. Staff did not have access to bridging beds or overnight carers whilst they waited for packages of care. Staff said that in North Norfolk it took over 3 weeks to put in place a package of care.

The lack of available beds due to the high number of patients with no criteria to reside led to the trust introducing a practice of adding additional beds into bays in December 2021. This meant that there would be 7 beds in a 6 bedded bay. This was initially intended as a temporary measure at a time of significant pressure within the system during the Covid-19 pandemic. However, the practice had continued throughout 2022. There were 92 escalation beds in use (including additional beds in bays) on the day of our inspection. We have reported on the impact of the use of additional beds in bays throughout this report.

Risk was not always shared equally amongst all agencies in the system and the trust was having to take on a significant proportion of the risk. However, staff noted that engagement from other agencies had significantly improved in 2022. Agencies in the Norfolk and Waveney system met multiple times per week to discuss challenges, review risks, find solutions and progress recovery plans. However, staff noted that there was a difference between the engagement they received from health providers and social care providers. Staff said that there was not always an agreement across the system to do things differently. Staff also said that the response from external agencies was not always urgent enough, and external agencies did not always have the same understanding of the requirement for change within the system as they did not always see the impact on patients. The trust was increasingly using data as a tool to highlight the impact on patients to the system. Staff had also recently brought representatives from care homes onto the wards to show them the impact of having to use additional beds in bays. The trust also used data to support the system to capacity plan and define the right type of capacity. Staff were keen to develop a clinical relationship between the teams in the hospital and the community.

The trust had implemented a range of alternative pathways in response to the lack of beds to admit patients. For example, the trust had introduced a virtual ward during the Covid pandemic. The virtual ward could accept up to 40 patients at the time of our inspection and the trust was continuing to expand this number. The trust also continued to expand the type of patients that could be accepted by the virtual ward and was continuing to develop the role of the virtual ward, including admission avoidance.

The trust continued to review the processes that they had in place to manage flow and made adjustments where required. This included engaging with other trusts to share learning. The trust had implemented a continuous flow model when they were at the highest operational pressure escalation level (OPEL 4). The trust had also created a Priority Assessment Unit (PAU) in October 2022, with a metric to pull 4 patients per hour (7.00am -10.00pm) from the emergency department.

Managers monitored the length of stay of patients. Data showed that the length of stay in medical care had increased to an average of 7.1 days between March 2021 and February 2022. Average length of stay was higher than regional and national averages. The trust had a length of stay task and finish group in place to identify internal efficiencies that could be made in this area. However, length of stay data was being impacted by the number of patients who were medically fit to leave the hospital.

Managers and staff started planning each patient's discharge as early as possible. Staff were required to document an estimated discharge date within 14 hours of admission and this was reviewed on a daily basis. However, staff did not always ensure that discharges occurred early enough in the day to facilitate flow through the trust. Data provided by the trust showed that in the 3 months prior to our inspection, 90.3% of discharges occurred after 12pm. Almost half (44.6%) of all discharges occurred between 5pm and midnight. The trust had a target of 25% of all discharges before 12 noon. Divisional leaders had identified this as an area of concern. They were regularly monitoring this concern and were working with internal teams to identify earlier discharges.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. The trust had an integrated discharge team with discharge nurses and discharge coordinators to provide information, support and advice to patients, relatives and staff. An electronic transfer of care document was completed by staff as part of the discharge process to provide social care staff with information about a patient's condition, support requirements, frailty, mobility and risks. Leaders regularly monitored the internal completion rate of the transfer of care document and also monitored the timeliness of the response from external agencies. Leaders liaised with external agencies to escalate the delays that were being experienced in the timeliness of response.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. Staff carried out red to green meetings twice a day to review patients on each ward. There were also daily trust level meetings which monitored the number of delayed discharges. The trust had also introduced executive reviews of 'super stranded' patients in the month before our inspection.

The trust was seeing an increase in the number of patients who were dying whilst awaiting discharge. Sixty patients had died whilst awaiting discharge in the month before our inspection. The trust had recognised this risk, had added it to their risk register and escalated concerns to the system.

Staff supported patients when they were discharged. For example, the trust used volunteers to carry out post-discharge safety netting calls with a welfare check to ensure that the appropriate level of support was in place. The trust also used volunteers to provide a settle-in service on the day of discharge.

Managers monitored the discharge process. The trust had a discharge lead, who monitored data relating to discharge, including the number and themes of incidents and complaints. The number of concerns raised about the discharge process by external agencies had remained steady and was an average of just 17 per month in the 3 months prior to our inspection.

Managers monitored the number of medical patients on non-medical wards. There were 35 medical outliers on the day of our inspection. Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards.

Managers monitored the number of patient moves between wards. The use of an electronic system gave staff an oversight of the number of times that each patient had been moved since their admission. Staff told us that the service moved patients when there was not a clear medical reason or when it was not in their best interest. Staff were also required to move patients between wards at night. Patients told us that they were being moved a significant number of times, including at night. For example, one patient told us they had been woken up at 12:30am and told they needed to be moved. Whilst they had refused, they stated that another patient over the age of 90 had been moved and the patient

was very disorientated. Staff also told us that patient moves impacted on discharge planning and patient experience. Data provided by the trust demonstrated that in the 3 months prior to our inspection, the average number of total bed moves per patient for non-clinical reasons was 1.5. The average number of overnight bed moves was 0.5, which meant that half of patients would have experienced 1 overnight bed move.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The medicine division had a clear senior management and leadership structure with a chief of division, divisional operational director and divisional nursing director. There were two sub-divisions within the medicine division, which also had their own triumvirate leadership structure.

Leaders had the skills, knowledge, experience and integrity that they needed. All of the divisional leaders had previous experience in a range of leadership posts within acute trusts which provided them with the skills and knowledge needed to carry out their roles.

Leaders understood the challenges to quality and sustainability and could identify the actions needed to address them. Leaders demonstrated a clear understanding of the challenges that the medicine division faced. Leaders regularly monitored the impact of staffing shortages, the use of escalation beds, and the challenges with the flow of patients through the system. Leaders were implementing a range of actions to address these challenges.

Leaders were visible and approachable. Staff provided positive feedback about the support provided by leaders when they escalated concerns to them.

During our inspection we observed that ward managers were required to work clinically due to staffing shortages. This impacted on their ability to provide management support to staff, including through appraisals and clinical supervision. This also impacted on nursing presence at meetings.

Culture

Morale amongst staff was low, but they felt supported and they were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

The culture was centred on the needs and experience of people who used services. Conversations with staff demonstrated they put patients at the heart of everything they did. Staff were focused on providing the highest quality care possible. However, morale amongst staff was low due to the impact of staffing shortages and the sustained pressure that the trust was under due to the challenges with flow through the system. Staff reported feeling exhausted and stressed.

The culture encouraged openness and honesty at all levels within the organisation. Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution. Staff felt able to escalate any concerns and felt that they received support in response. However, staff noted that it was not always possible for leaders to address concerns relating to staffing shortages or the use of escalation beds. In some cases, staff said that this led to them no longer raising concerns.

There was improved evidence of collaborative working between leaders and staff to address areas of concern. Staff were increasingly being encouraged to 'own' the solutions to problems identified within their own clinical areas. For example, staff had raised concerns about the flow of GP referred patients into the Priority Assessment Unit (PAU). Divisional leaders had discussed these concerns with staff and had implemented their suggestion to revert an area of the Acute Medical Unit (AMU) back to GP referred patients. Another example was provided where staff had escalated that changes made to the process for the older person's emergency department was not working. The divisional leaders had met with staff and agreed to move the process back. Leaders had also held workshops with staff on the wards to discuss and find solutions to the practical implications of the use of additional beds in bays.

There was an emphasis on the safety and well-being of staff. The trust and the medicine division had implemented a range of wellbeing measures to support staff. For example, a 3-month pilot was being carried out in the division to focus on staff breaks and structured supervision. A clinical educator provided ongoing pastoral support to new healthcare assistants. Professional nurse advocates had been introduced as a supportive mechanism for staff. Staff provided examples of adjustments that had been made to support their wellbeing based on their individual circumstances. For example, one member of staff said that an agreement had been made that they would not be redeployed to work on other wards based on their experience of anxiety relating to being redeployed.

There were cooperative, supportive and appreciative relationships among staff. All staff spoke positively about the relationships with their colleagues.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

There were comprehensive assurance systems and performance issues were escalated appropriately through clear structures and processes. Each of the specialties within the medicine division met at monthly clinical governance meetings to review and discuss their performance. Any issues that were identified during these meetings were escalated up to divisional meetings. Our review of the last 3 months of meeting minutes as part of our inspection confirmed that this escalation process was regularly and effectively utilised by staff. Divisional leaders noted that staff would not wait for clinical governance meetings to escalate issues; issues were reported and dealt with on a daily basis.

Divisional leaders were regularly monitoring the areas of concern that we focused on during our inspection. For example, the divisional lead nurse attended a range of meetings to monitor nurse and healthcare assistant staffing shortages. This included a weekly meeting with senior matrons to review and discuss data on staffing red flags and staff redeployment. The divisional lead nurse also had monthly meetings which were dedicated to reviewing data on vacancy rates, establishment levels, recruitment plans, and a review of off-duty rotas.

During our review of divisional board meeting minutes for the 3 months prior to our inspection, we found that on some topics, such as serious incident data and complaints data, there was a tendency for attendees to note the data that had been presented without further discussion or action. However, it was clear during our inspection that these topics were being regularly discussed and actioned in other forums.

There were processes to manage current and future performance. A monthly performance report was produced for divisional leaders. This gave leaders an oversight of a range of quality and performance data for the division. The report also included an analysis of whether there was any correlation between staffing shortages and quality metrics. However, divisional leaders did not monitor data on call bell response times. Staff spoken with during our inspection had highlighted delays in the response to call bells as one of the key areas being impacted by staffing shortages. However, divisional leaders monitored a wide range of other metrics relating to the quality of care. Divisional leaders stated that if a particular ward was highlighting as a concern based on these quality metrics, additional support would be provided to the ward.

There was a systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken. Divisional leaders were able to monitor the quality of the service through a range of regular audits being undertaken on all wards. Actions were identified when areas of concern were identified through these audits. However, as part of our inspection we identified 2 areas of concern which had not been identified through these audits. This related to the completion of daily checks of resuscitation trolleys and the reassessment of patients' physiological observations. In addition, we found that staff did not always ensure that action plans were updated to confirm that actions had been completed. Information provided by the trust showed that 2569 actions out of a total of 2727 actions were overdue on date of our inspection and remained open. However, the trust noted that "on review many of these aren't true actions". Divisional leaders planned to introduce action planning sessions to address this.

There were robust arrangements for identifying, recording and managing risks, issues and mitigating actions. There was scoring and controls in place for each risk on the risk register. There was evidence that risks were regularly reviewed and each risk had an anticipated closure date. There was an alignment between the recorded risks and what staff said was 'on their worry list'.

Potential risks were taken into account when planning services and the impact on quality and sustainability was assessed and monitored. For example, the service had carried out risk assessments relating to the use of additional beds in bays. These risks had subsequently been added to the risk register and these were monitored by divisional leaders on an ongoing basis.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.

Leaders and staff strove for continuous learning, improvement and innovation. The medicine division was involved in a range of quality improvement projects, including falls, nutrition and hydration, and deconditioning. Staff had taken on this quality improvement work despite the challenges that they faced.

There were systems in place to support improvement and innovation work. The trust had a quality improvement (QI) team, which acted as a hub for knowledge on programme and project management. The team tracked milestones and key performance indicators (KPIs) and would escalate issues to a senior level where necessary. The medicine division also had a dedicated quality improvement nurse.

Staff used standardised improvement tools and methods. The quality improvement team supported staff to use the plan-do-study-act (PDSA) model for improvement where appropriate.

Medical care (including older people's care)

Staff regularly met to review progress and discuss challenges. The trust had a falls steering group and a nutrition steering group, which met regularly to discuss initiatives, monitor progress and address any challenges.

Outstanding practice

We found the following outstanding practice:

- The medicine division was involved in a range of quality improvement projects, including falls, nutrition and hydration, and deconditioning. Staff had taken on this quality improvement work despite the challenges that they faced.
- Conversations with staff demonstrated that whilst they were exhausted and their morale was low, they continued to put patients at the heart of everything they did. Staff were focused on providing the highest quality care possible. This was confirmed through our observations of care.

Areas for improvement

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

Action the trust MUST take to improve:

- The trust must ensure that patients' physiological observations are reassessed and recorded in line with trust policy. (Regulation 12(2)(a))
- The trust must ensure that risk assessments relating to the health, safety and welfare of people using services are completed and reviewed in accordance with trust policy. (Regulation 12(2)(a))
- The trust must ensure that resuscitation equipment is checked in accordance with trust policy. (Regulation 12(2)(e))
- The trust must ensure that patients have drinks and call bells within reach. (Regulations 14(4)(a) and 9 (1))
- The trust must ensure that work to improve the support that patients receive to meet their nutritional and hydration needs continues. (Regulation 14(4))
- The trust must ensure that intentional rounding is carried out and recorded in accordance with trust policy. (Regulation 12 (2)(b))

Action the trust SHOULD take to improve:

- The trust should ensure that nursing and healthcare assistant staffing levels continue to be regularly monitored and adjusted when required. Work to increase staffing levels in order to meet establishment levels should continue. (Regulation 18(1))
- The trust should ensure that monitoring of compliance and risk assessment of the trust policy for the use of additional beds in bays continues. (Regulation 15(1)).
- The trust should ensure that actions identified following the completion of local audits are implemented. Action plans should be updated when actions have been implemented. (Regulation 17 (2))

Medical care (including older people's care)

- The trust should continue to work closely with all system partners to tackle the capacity pressures on urgent and emergency care in the health and social care system in Norfolk and Waveney.
- The trust should continue work to improve Friends and Family Test response rates.
- The trust should continue work to improve the time of day that patients are discharged.
- The trust should work to reduce the number of patient moves for non-clinical reasons, particularly during night-time hours.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, an inspection manager, another CQC inspector and an expert by experience. The inspection team was overseen by Zoe Robinson, Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

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