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	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Norfolk and Norwich University Hospital

Inspected but not rated

Norfolk and Norwich University Hospitals NHS Foundation Trust operates primarily across two sites:

- Norfolk and Norwich University Hospital (NNUH) – this was built in 2001 and is based on the Norwich Research Park. Care is provided for a tertiary catchment area from Norfolk and neighbouring counties.
- Cromer and District Hospital – this was rebuilt by the Trust in 2013. It has a minor injuries unit and provides a range of outpatient and day-case services.

We carried out an unannounced focused inspection of Cromer Minor Injuries Unit (MIU) and medical care services (including older people's care) at Norfolk and Norwich University Hospital, on 16 February 2022. We also had an additional focus on the urgent and emergency care pathways across Norfolk and Waveney and carried out a number of inspections of services in a few weeks. This was to assess how patient risks were being managed across the health and social care services during increased and extreme capacity pressures.

As this was a focused inspection for Norfolk and Norwich University Hospitals NHS Foundation Trust, we only inspected parts of our five key questions. For both core services we inspected parts of safe, effective, responsive, caring and well-led.

Medical care was previously rated as requires improvement overall with caring and responsive rated as good.

For this inspection we considered information and data on performance for medical care. This inspection was partly undertaken due to the concerns this raised over how the organisation was responding to patient need and risk in the emergency care and the wider trust in times of high demand and pressure on capacity. We were concerned with the waiting times for patients, delays in their onward care, treatment and delayed discharges, as well as delayed and lengthy turnaround times for ambulance crews.

We looked at the experience of patients using medical care services in In Norfolk and Norwich University Hospitals NHS Foundation Trust. This included the medical wards and areas where patients in that pathway were cared for while waiting for treatment or admission. We also visited wards where patients from the emergency department were admitted for further care. This was to determine how the flow of patients who started their care and treatment in the emergency department and those cared for on medical wards, was managed by the wider hospital.

A summary of CQC findings on urgent and emergency care services in Norfolk and Waveney.

Urgent and emergency care services across England have been and continue to be under sustained pressure. In response, CQC is undertaking a series of coordinated inspections, monitoring calls and analysis of data to identify how services in a local area work together to ensure patients receive safe, effective and timely care. We have summarised our findings for Norfolk and Waveney below:

Norfolk and Waveney

Our findings

Provision of urgent and emergency care in Norfolk and Waveney was supported by services, stakeholders, commissioners and the local authority. The health and care system in this area lies across a large, predominantly rural, geographical area with a large proportion of the population aged over 65 years.

Compliance with CQC regulations has historically been challenging across Norfolk and Waveney, particularly in Acute, Mental Health and Adult Social Care services, many of which have been rated Requires Improvement or Inadequate.

We spoke to staff in services across primary care, urgent care, acute, ambulance services, mental health and adult social care. Staff told us of increased pressure across urgent and emergency care pathways, staffing issues and a lack of capacity in key sectors including GP and Dental practices and social care. These issues were resulting in inappropriate calls to 999 and attendances in emergency departments. There were delays in discharge for patients who were medically fit but unable to access appropriate packages of care to enable them to leave hospital.

We previously inspected mental health services in the Norfolk and Waveney area in November and December 2021 and found, due to an increase in referrals and staffing shortages, patients in the community had long waits to be seen. This led, in some cases, to patients deteriorating and requiring urgent and emergency treatment. In addition to this, some inpatient services (such as CAMHS) did not have available beds within the area. Patients were kept in urgent and emergency care settings whilst a bed was found. During inspections of acute services, we found patients unable to access appropriate and timely care to meet their mental health needs.

We inspected a number of GP practices and found some concerns in relation to access for patients trying to see or speak to their GP. We found high levels of staff absence resulting in some staff working long hours and experiencing increased pressure on their services.

To try and alleviate the increasing demand on Emergency Departments, GP streaming services had been introduced in EDs in Norfolk and Waveney. Patients who presented at the ED with problems which were deemed suitable for a primary care appointment could be referred to a co-located primary care service. In some cases, streaming services helped to prevent up to 33% of patients attending the ED.

We inspected urgent care services in the Norfolk and Waveney area and found these to be well-run. However, an on-going shortage of out of hours and urgent care appointments, particularly for urgent dental care, meant patients couldn't always be appropriately signposted by NHS111. This meant patients often presented to ED for treatment. NHS111 in Norfolk and Waveney had also experienced significant staff shortages, much of which has been due to the COVID-19 pandemic. Leaders in this service had a recovery plan in place; however, staff shortages and increased demand had resulted in significant delays in call answering and call-back times in comparison to the national targets and there was also a very high call abandonment rate, meaning people ended the call before speaking to an advisor. Whilst performance across Norfolk and Waveney did not meet national targets and people experienced significant delays, these delays were, on average, shorter than regional and national averages

We inspected emergency departments (ED) in Norfolk and Waveney between December 2021 and February 2022 and found lengthy delays for people accessing emergency care. A high number of patients were waiting over 12 hours in ED resulting in overcrowding. This impacted on ambulance handovers and further delays in releasing ambulance crews into the community to respond to 999 calls.

Staff shortages have had a significant impact on social care services across Norfolk and Waveney. In addition, the provision of domiciliary care services is challenging due to the rurality of the area. At the time of our inspections, a care hotel was being utilised in Norfolk and Waveney. We spoke to healthcare professionals who had provided services to

Our findings

people being cared for at the hotel and found them to be safe and generally well cared for. The number of people receiving care in the hotel was small and the aim was for them to only stay for a very short amount of time before going home. This service is commissioned until the 30 April 2022, a formal evaluation will take place before any future plans are agreed.

Some social care and learning disability services in Norfolk and Waveney have struggled to achieve compliance with CQC regulations and a rating of good. Some support has been established across Norfolk and Waveney to help services improve. However, the impact of any support to date has been limited.

Staff shortages and service quality has significantly reduced capacity across social care and learning disability services in Norfolk and Waveney. This has 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. These delays and poor flow resulted in overcrowded EDs and an inability to transfer patients from ambulances.

Strategic, system wide workforce planning and increased community provision of health and social care is needed to meet the needs of the local population. This is needed to reduce the pressure on urgent and emergency care services and to reduce the risk of harm to people living in Norfolk and Waveney.

Summary of Norfolk and Norwich University Hospitals NHS Foundation Trust – Norfolk and Norwich University Hospital

- The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well.
- Managers monitored the effectiveness of the service. Staff worked well together for the benefit of patients, supported them to be involved in decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

However:

- The service did not always have enough staff to care for patients and keep them safe.
- Although people could access the service when they needed it they did not always receive the right care promptly due to pressure on bed capacity. 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.

How we carried out the inspection

Our findings

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

During the inspection we observed care, spoke with 35 members of staff and carried off site interviews with the senior leadership team. We spoke with 15 patients and one carer. We observed care provided; attended site meetings, reviewed relevant policies and documents and reviewed ten patient records.

Medical care (including older people's care)

Inspected but not rated

Is the service safe?

Inspected but not rated

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.

All areas we visited were visibly clean and suitable furnishings which were clean and well-maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

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 including surgical face masks in line with national guidance. All clinical staff were bare below the elbows. We observed staff washing their hands before and after delivering care. Hand gel dispensers were full and additional hand gel stations were available for staff and visitors.

There was rapid testing available for COVID-19. A member of staff in the older persons emergency department told us that they were able to get COVID PCR tests within 30 minutes. This meant that patients that arrived at hospital with community acquired COVID infection could be quickly identified and cared for in the appropriate setting.

There were designated wards for patients with COVID-19 symptoms or were known to be COVID-19 positive. Staff knew which wards were allocated to care for these patients. There was a trust policy in place defining how to provide care to this patient group and all staff we asked were aware of how to treat these patients.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Environment and equipment

The use of temporary escalation bed spaces for patients was recognised as below the standard the trust would expect. Although, the use of escalation beds was necessary due to capacity within the hospital and was being managed as safely as possible.

Most patients could reach call bells and staff responded quickly when called. Due to capacity issues the hospital was utilising surge capacity, caring for patients in corridor areas and boarding patients meaning that there were additional beds in bays on some of the wards. Where patients were “boarding” on a ward in an additionally created bed space in a bay or corridor, portable oxygen suction and call bells were available.

Medical care (including older people's care)

Where patients were cared for in temporary beds staff assessed patients following set criteria to determine whether they were well enough to be cared for in these areas. The hospital had a policy in place for using these bed spaces and clear guidance for staff to follow. We observed that staff did follow the policy identifying patients to be cared for in these areas and carried out risk assessments. It was recognised by staff and the trust leadership team that the environment was not suitable for patients remaining for long periods or for treatment.

The design of the environment did not always follow national guidance due to additional patients boarding on the ward. Where an additional patient was boarded on a six-bed bay, we observed that there was insufficient space between beds. There, was not space for a chair beside the bed meaning that the patient was unable to sit out of bed. On Kimberley ward we observed a patient sitting in the middle of the bay at a table. This meant that access was restricted to some of the patient beds in the bay.

Staff carried out daily safety checks of specialist equipment. All areas we visited had emergency resuscitation trolleys available. These were locked and secured appropriately, and checks were completed in line with trust policy.

Staff disposed of clinical waste safely. Staff used separate designated waste bins for general and clinical waste disposal.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Observations were recorded electronically. This would automatically alert the critical care outreach team enabling them to quickly identify deteriorating patients and support staff on the ward.

The use of an electronic system meant that senior clinicians were readily aware of the clinical risk of unwell patients. The electronic system fed into 'ward view', an electronic dashboard located on each ward. This dashboard flagged patients with high NEWS2 score, specialty, dementia flag, numbers of internal bed moves and which bays had additional beds. This gave good oversight in real time of acuity and patient need on the ward.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed eight patient records and saw risk assessments were completed on admission and reviewed regularly and when any change occurred. Risk assessments were recorded on the same electronic system used to record observations.

Staff knew about and dealt with any specific risk issues. Additional assessments were completed for patients where additional risk was identified. For example, where a patient was at risk of falling, a full falls risk assessment was undertaken and actions were put in place to reduce the risk in line with the trust falls policy. These were recorded in the patients record. Staff used a sepsis screening tool to risk assess patients that had red flag signs that they may have sepsis. We saw that this tool was used by staff in the records that we reviewed.

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). The mental health liaison team (MHLT) were available to support staff in meeting the mental health needs of patients. MHLT staff were based within the emergency department and ensured regular communication following assessment with trust staff, including details of current care plans, risk assessments and expected outcomes.

Medical care (including older people's care)

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The trust employed seven mental health nurses who supported the acute medical staff with care plans, risk assessments and providing therapeutic working in conjunction with MHLT.

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.

Nurse staffing

Senior managers recognised that shortages of nursing staff meant that the service did not have enough staff with the right qualifications, skills, training and experience to keep patients safe from the risk of avoidable harm. Managers were not always able provide the planned staffing levels despite regular adjustments to ward staff levels.

Due to a national shortage of nursing and support staff and high levels of staff absence, the service did not always have enough nursing and support staff to keep patients safe.

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. Site meetings were held throughout the day reviewing staffing and moving staff to areas that were short staffed as required. These meetings managed staffing and responded to requests for support from the wards. Additional staffing requirements were discussed with the wider management team at site meetings.

The ward manager could adjust staffing levels daily according to the needs of patients. Staff told us that this was done when caring for additional patients and in opened escalation areas. 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.

The number of nurses and healthcare assistants did not always match the planned numbers. On the day of our inspection none of the areas we visited had the planned number of nursing staff. Staff told us that even when a shift started with the planned number of staff, due to staff moves to cover in other areas this did not often remain the case.

There was a clear escalation process for the use of bank and agency staff. Where possible staff requested bank and staff familiar with the service.

The trust had a number of recruitment initiatives in place for registered nurses and health care assistants. A cohort of overseas nurses were arriving in March with 60 nursing staff being allocated to the medicine division. The management team told us that they were working with universities offering roles that covered mixed specialities and offering flexible hours to help attract nursing staff to the trust.

The trust had undergone a review of health care assistant (HCA) establishment on the wards and this had been increased by 23%. In order to improve retention of this staff group, a band seven post had been implemented to support new starters. The band seven role had a positive effect, out of 136 new HCAs employed by the trust only three had left the organisation.

Medical staffing

Medical care (including older people's care)

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Staff told us that there was enough medical staff to keep patients safe.

Data provided by the trust showed the vacancy rate for medical staff was 29%. However turnover and sickness rates were low.

The chief for division for medicine told us that there was an ongoing workforce review to address identified staffing gaps in the acute medicine unit.

There was a monthly safer staffing committee established to provide oversight and assurance to ensure that staffing levels were appropriate to provide safe care and treatment for patients.

The service used locum staff. Managers could access locums when they needed additional medical staff.

Managers told us that they made sure locums had a full induction to the service before they started work.

The service had a consultant on call during evenings and weekends.

Records

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

Patient notes were comprehensive and all staff could access them easily. All records were electronic including NEWS 2 and electronic prescription charts. We reviewed seven sets of records and found then to be comprehensive and completed appropriately.

The electronic records system fed into ward view which was an electronic dashboard on each ward that flagged patients with high NEWS scores providing staff with a comprehensive overview of the acuity of patients on the ward.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. We observed that staff logged out off when leaving workstations ensuring that only those authorised could access patient records.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff completed medicines records accurately and kept them up to date. We reviewed multiple people's medicine administration records across the medicine wards visited. Electronic and prescribing administration (EPMA) records showed that medicines were being administered safely and in line with the prescriber's intentions.

Medical care (including older people's care)

Staff stored and managed all medicines and prescribing documents safely. Medicines were stored safely and securely on each of the wards visited. Access was limited to authorised staff only and in areas where non-medicines trained staff could access the rooms the medicines were locked away in cabinets.

Controlled drugs (medicines with additional storage requirements) were stored and checked regularly in line with Trust policy. These were checked once a week by staff.

Temperature monitoring of the food fridges was completed by the ward housekeepers and drug fridges by trained staff. Records showed that this was not always being completed daily however temperature ranges appeared stable.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

Medicines reconciliation (the process of accurately listing a person's medicines) was completed when on admission to the hospital. This occurred either in the medical assessment unit or on the ward in the case of a direct admission. Pharmacists and pharmacy technicians were responsible for completing this and most patients had a completed medicine reconciliation completed within 24 hours of being admitted.

On discharge the ward staff ensured that patients were counselled and left the service with enough medicines to meet their needs. If they were being discharged to a social care provider then relevant information would go with the patient to ensure the receiving service was able to meet their medicine needs.

Staff learned from safety alerts and incidents to improve practice. There was a system in place from pharmacy to monitor and act on medicines safety alerts.

The trust used an incident reporting system to record near misses and errors. Staff told us that medicines safety learnings from this was shared more widely in the trust through team meetings and the pharmacy bulletins.

We were able to talk to staff about recent medicine incidents and they told us about how practice had been altered to mitigate the chances of similar incidents happening in the future.

Is the service effective?

Inspected but not rated

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits and produced action plans from the results. We reviewed the audit plan for medicine for 2021-22 and saw that this included national audits, for example the Sentinel Stroke National Audit Programme (SSNAP) as well a programme of regional and local audits

Managers and staff used the results to improve patients' outcomes and improvement is checked and monitored. For example, actions were put in place to improve the identification of potential patients for kidney transplant as an outcome of an audit of renal transplant.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. There was an ongoing local audit programme with action plans.

Managers used information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits. Audit results were shared by email and discussed at monthly meetings.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time.

Managers shared and made sure staff understood information from the audits.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. There was an established and effective process in place for referrals between specialties.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Daily board rounds took place on each ward attended by a multidisciplinary team to discuss the patients on the ward. This included patient's diagnosis, treatment plans, any concerns around the patient's condition and discharge plans.

Staff worked across health care disciplines and with other agencies when required to care for patients. We saw evidence of multidisciplinary working throughout our inspection and saw evidence in the records we reviewed. Staff told us that access to social services had been more difficult since the pandemic when teams had not had access to the site. They told us that they felt this had impacted on aspects of discharge planning when the social work team were not able to meet with the patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression.

Patients had their care pathway reviewed by relevant consultants. Patients had a timely consultant review on admission and throughout their stay during daily ward rounds. For patients that were being cared for outside of a specialty ward, consultants would visit them on the ward where they were residing.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. We reviewed the notes of seven patients and found they all had clinical assessments undertaken by a consultant within 12 hours of admission as required.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Staff we spoke with told us that there was good access to these services.

Medical care (including older people's care)

Staff told us that access to social services including discharge teams were available Monday to Friday. This meant that there was not access to this service at weekends to support the safe discharge of patients. Staff told us that they felt this impacted on the number of discharges completed over the weekend.

Is the service caring?

Inspected but not rated

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff interacting positively with patients and treating them with care and compassion.

Patients said staff treated them well and with kindness. All the patients we spoke with told us that they were happy with the care they received. One patient told us that staff were very kind and another told us that the staff were providing them with very good care.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. At the time of the inspection there were three patients waiting for a specialist mental health bed who were being cared for on the Medical Assessment Unit (MAU). Staff demonstrated a non- judgemental and caring attitude when discussing these patients with us whilst at the same time acknowledging that the acute hospital was not the correct setting for these patients to be cared for to meet their needs.

Emotional Support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients and helped them maintain their privacy and dignity. However, this was a challenge in bays where additional patients were boarding. Where there were seven patients in a six bedded bay, the patients were closer together and there was not a curtain to go around each bed. Dignity screens were available for use when required. Patients we spoke to in these bays told us that they did not feel that their privacy or dignity had been compromised.

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.

Medical care (including older people's care)

Due to restrictions of access to the hospital due to the COVID-19 pandemic visitors were not able to come to the hospital at the time of our inspection. However, patients that were end of life, living with dementia or patients with learning difficulties were able to be supported by relatives and carers.

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 made sure patients and those close to them understood their care and treatment. All patients we asked had had their care explained to them and told us that they had the opportunity to ask questions. Patients told us that they were aware of their discharge plans and for vulnerable patients their relatives or carers were involved in plans of care following discharge and for reasons for any delays.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Staff supported patients to make informed decisions about their care. Patients we spoke with told us that they had been involved in decisions about their care and discharge plan. Patients who were boarding on a ward in an additional bed space told us that they had been informed by staff and had agreed to reside in the additional bed space in order to access care.

Patients gave positive feedback to us on the day of inspection about the service and the treatment they were receiving.

Is the service responsive?

Inspected but not rated

Service planning and delivery to meet the needs of the local people

The service worked with system partners to plan services to meet the needs of local people. Due to pressures on bed capacity, there were times when patients were cared for in areas not designed for that purpose. The service worked with others in the wider system including health care providers and social services to facilitate patient discharges to appropriate onward care. settings.

Managers planned and organised services, so they met the changing needs of the local population.

The service had a same day emergency care area (SDEC). This service was available for GP referrals including a direct telephone line access for advice and referrals answered by a consultant from 8am to 8pm seven days a week. Managers told us that decision regarding best care pathway were made in conjunction with the patient, clinician and GP. Outside of these hours patient was then cared for in the acute medical unit. (AMU).

The trust had a day unit available where patients could be seen and treated in one day.

Medical care (including older people's care)

The service had systems to help care for patients in need of additional support or specialist intervention. For example, the trust had an older person's emergency department (OPED) which looked after all patients over 80 on an acute pathway. There was a dedicated phone line answered by a consultant between 8am and 5pm offering clinical advice to GPs and paramedics to prevent unnecessary admission to the hospital.

There was an older person's ambulatory care (OPAC) unit which offered same day care to patients at the hospital. However, the OPAC was closed at the time of our inspection due to staffing and bed pressures. Senior leaders told us that although OPAC was closed due to the physical space being used the service was still able to see patients.

The trust provided an acute oncology service which was available seven days a week. This service meant that high risk patients could have direct access to services without having to access the hospital via the emergency department.

Facilities and premises were appropriate for the services being delivered. However, capacity issues meant that some areas were not being used as designed. For example, the OPAC was now being used as a medical ward.

Staff could access emergency mental health support 24 hours a day seven days a week for patients living with mental health problems, learning disabilities and dementia. For example, all referrals to the mental health liaison team based at the trust were made using an electronic referral system although a telephone call to discuss the referral detail and pathway was encouraged in the first instance to ensure the most appropriate and timely response to meet the needs of the patient.

Senior leaders attended twice daily system calls where an overview was given of the current risks system wide. We observed a meeting and saw that all providers in attendance gave an update on capacity issues from the ambulance service, the acute hospital, community hospital, mental health and adult social care and updated on actions they were taking.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

Wards were designed to meet the needs of patients living with dementia. The trust had a dementia support team which provided personalised care and support to patients living with dementia and their carers. More than 140 staff from all parts of the trust acted as dementia links and had a special interest in caring for patients who were living with dementia.

The trust had a small team of acute liaison nurses whose role was to make sure patients with learning disabilities and/or autism stay in hospital was as good as possible. They supported hospital staff caring for patients with learning disabilities and/or autism and provided training.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. This is the form a booklet completed by patients and carers which is shared with staff and provides background, current and past interest, and routines that are important to the patient to help staff meet their needs whilst they are in hospital.

Medical care (including older people's care)

The needs of these patient groups were considered when considering changes to pathways to manage ongoing capacity concerns. For example, patients from these groups were excluded when considering boarding patients to accommodate additional patients on the wards

Access and flow

People could access the service when they needed it but did not always receive the right care in the right place promptly, due to pressures on bed capacity. 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.

The hospital had significant capacity problems due to the availability of beds to admit patients. This was in part 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. On the day of our inspection there were 134 patients with no criteria to reside. Fifty six percent of these patients were waiting for onward care packages or repatriation to another hospital setting. Most patients (71) were waiting for care pathway two. This group of patients required transfer to a non-acute bed to receive rehabilitation and assessment until they can return home safely.

Managers monitored delayed discharges for each ward throughout the day and they took action to prevent delayed discharges. Managers had clear oversight of the number of patients with no criteria to reside and the reason that they could not be safely discharged. This was monitored throughout the day and action taken to support staff to discharge patients as soon as possible. One member of staff told us that pressure on staffing had impacted on discharge planning as staff needed to focus on patient safety rather than 'chasing' issues relating to discharge.

The wards reviewed patients daily using the red and green bed days. The approach is used to reduce internal and external delays. Patients were reviewed daily and were kept informed and involved in their treatment plan. An audit had been carried out in February 2022 to monitor patient's knowledge of their treatment. The data showed that although 81% of patients knew what needed to happen before they left hospital, only 33% knew when they expected to be discharged.

At the time of our inspection the discharge lounge had been relocated due to the need for the trust to create additional capacity to support the elective recovery. The discharge area was temporarily located on the acute medical unit area K (AMUK) which was also being used as an escalation area to help improve flow in the hospital. We observed patients waiting in a side room or in the corridor on AMU-K for transport. Staff told us that due to limited space they felt that the flow of patients through the discharge area had reduced. This meant that more patients awaiting discharge were waiting on the ward impacting on admitting new patients. Managers told us that data demonstrated that transferring the discharge area from the day unit to AMUK had not adversely affected the discharge profile. They told us that an alternative location and action needed to be taken by the senior leadership team to review the decision and ensure that the future location was sustainable.

Managers monitored patient moves between wards/services. The use of an electronic system gave manager oversight of the number of patient moves. At the time of our inspection the hospital was undergoing severe capacity issues, and this resulted in some patients being moved many times. For example, we spoke to one patient who had been admitted to AMU, was in an additional bed in a bay on the ward and was due to be moved again when a bed became available.

Staff planned patients discharges carefully, particularly for those with complex mental health and social care needs. The trust had a complex discharge team where specialist discharge nurses supported ward staff to review and assess patient

needs and access the appropriate follow on care. A specialist discharge nurse told us that that the blockages they identified were the availability of staff in the community to deliver the care the patients needed and staffing shortages in the adult social care providers. In Norfolk and Waveney, services were more accessible in and around Norwich, but it was more challenging to access services in the north and south of the area.

Managers and staff worked to make sure patients did not stay longer than they needed to. The service monitored the length of stay of patients. Data provided by the trust showed that the average length of stay had increased over the previous six months but it should be noted that at the time of inspection 134 patients were medically fit to leave the hospital, so this impacted on the length of stay data.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. The trust operated a specialty ward-based system within the medicine division with specialty review of patients on non-specialty wards according to clinical need. At the time of our inspection 33 medical patients were residing on a ward outside of the speciality they were being treated under or on a non-medical ward. The medicine division held a daily morning report meeting for all on-call staff attended by specialty consultants. At this meeting a clinical handover occurred, and any patient moves resulting in outlying patients were highlighted and noted by each specialty. All wards also carried out morning multidisciplinary red to green meetings and subsequent board round meetings at which any patient moves to outlying wards are identified. The trust told us that daily consultant review of all inpatients took place. Staff on the ward confirmed that patients outlying on their ward did have a daily review and that medical clinicians were responsive if they needed to escalate concerns about their patients.

The trust had completed a pilot which resulted in a patient outliers policy and risk assessment which is going through our governance approval process.

Managers worked to minimise the number of medical patients on non-medical wards. Medical teams focused on early discharge from outlying wards, or clinically appropriate repatriation of patients to a medical specialty ward as required.

The trust had recently opened a ward to accommodate medically optimised patients that were on a discharge to assess pathway. The 30-bed ward provided care to patients that had the ability to be enabled and was focused on supporting patients with rehabilitation to enable them to return home.

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.

Leaders had the skills and abilities to run the service and we saw that they were actively engaged and committed to safe patient care and supporting their staff. Leaders were aware of the challenges facing staff due to the pressure the service

was facing. Leaders were aware of issues with delayed discharges impacting on flow and were working to maintain patient safety whilst taking action to address capacity and flow issues. For example, in January 2022 the trust took part in a multi-agency event to address the issues relating to blockages to discharging a patient. The multiagency discharge event (MADE) managed to expediate the discharge of 20 patients. Learning from the event has been shared resulting in a 30, 60, 90-day plan led by the integrated care system (ICS).

Staff told us that leaders were visible and accessible, and they felt that there was effective communication. However, some members of staff told us that they did not feel that they were consulted when changes were made in their service in response to managing access and flow for patients in the hospital. Staff told us that they felt able to escalate concerns.

Staff morale was good although there was a sense that staff had no choice but to keep going in response to the immense and unrelenting pressure that the trust and staff had been experiencing over the past two years. Most staff we spoke to told us that their health and wellbeing was supported by leaders although some staff felt that staff wellbeing was not always taken into consideration when the trust was experiencing such high demand.

The trust had an associate director for complex health and safeguarding to support staff when caring for these patient groups. At the time of our inspection there were five patients being cared for at the hospital who were assessed as requiring a bed in a mental health setting. One patient was being cared for in a room in the emergency department and had been there waiting for a bed in an inappropriate setting for 12 days. The associate director had oversight of these patients, ensured that there was appropriate assessment, input from the mental health liaison team and support for staff caring for these patients. There was daily escalation to the wider system, but staff told us that the care of mental health patients in an acute setting was an ongoing concern due to lack of capacity in the mental health sector.

Management of risk, issues and performance

The service had processes for recording, reviewing and managing risk. The service had a comprehensive risk register which was reviewed regularly. The risk register recorded the risks as identified by leaders during our inspection.

Leaders in the service attended quality and performance meetings and made contributions to improve the service. Leaders had clear oversight of risk and performance and the action being taken to address these.

Staff told us that they were informed by leaders of the risks in the service and the wider trust was facing daily and were aware of the actions being taken. However, some staff expressed concern about some of the actions being taken. For example, two members of staff told us that they felt boarding patients in their area increased risk to patients. Another told us that the continuous need to move staff to cover in different areas was impacting on staff morale and staff competencies.

Managers from the service took part in daily site meetings which focused on improving flow through the hospital. The meetings were attended by colleagues from across the trust meaning risk could be considered across the whole site.

Senior leaders attended twice daily system calls where an overview was given of the current risks system wide. We attended a meeting and observed that all providers were experiencing capacity issues from the ambulance service, the acute hospital, community hospital, mental health and adult social care. From the meeting we attended it was not apparent that a system wide approach was in place to facilitate flow and each individual provider was managing their capacity issues in isolation.

Medical care (including older people's 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 SHOULD take to improve:

Norfolk and Norwich University Hospital – Medical 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 to regularly review the nursing staffing levels in order to increase these to meet establishment levels. The trust should continue to monitor compliance and risk assess the trust policy for boarding patients.
- The trust should continue to review the impact of the closure of the discharge lounge and expediate plans for it's relocation to an appropriate setting.