Care Quality Commission

Norfolk and Norwich University Hospitals NHS Foundation Trust

Cromer 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 Cromer 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) 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 the urgent and emergency core services we inspected parts of safe, effective, responsive, caring and well-led.

The MIU has not been inspected insolation using the Care Quality Commission's comprehensive inspection methodology, however, the service has previously been incorporated in inspections of urgent and emergency care inspections. Urgent and emergency care was previously rated as good overall with responsive rated as requires improvement.

For this inspection we considered information and data on performance for the MIU. 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 the MIU at Norfolk and Norwich University Hospitals NHS Foundation Trust. This included the MIU 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:

Our findings

Norfolk and Waveney

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.

Our findings

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 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 – Cromer Hospital

- The service had enough staff to care for patients and keep them safe. Staff had training and understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records.
- Managers monitored the effectiveness of the service. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs.
- People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

However:

- Staff compliance with safeguarding children at level three fell short of the trust target.
- The capacity of the environment was not suitable for the number of people who attended.

How we carried out the inspection

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.

Our findings

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.

Urgent and emergency services

Inspected but not rated

The Minor Injuries Unit (MIU) at Cromer Hospital is run by experienced nurses with experience in urgent and emergency care, who can see and treat all forms of minor injury in patients age over 12 months with:

- Minor head injuries (with no loss of consciousness/no vomiting or on blood thinning medications)
- Simple wounds
- Simple eye injuries, for example if you have something in your eye or a scratch on the eye
- Minor burns
- Sprains and Strains
- Soft tissue injury, for example bites and stings but call 999 if you have quick swelling or struggle with your breathing
- Simple broken bones

The service was unable to treat patients:

- Patients under the age of 12 months
- Any minor illness presentations
- Complicated or serious injury including acute back and hip injury.
- any injury as a result of high energy- such as high speed road traffic accident or fall from height.
- Head injury where there is evidence of loss of consciousness / vomiting within 24 hours/ antegrade or retrograde amnesia/ anticoagulation therapy.
- Medical conditions in their acute form, asthma, diabetes, allergic reaction
- Major illness i.e. Stroke, Heart attack (these patients should attend the Accident and Emergency department at Norfolk and Norwich University Hospitals).

The MIU is open seven days a week 8am to 8pm. Patients access the service through self-referral, either by phone or walk in, GP’s and 111 also refer to the service.

Is the service safe?

Inspected but not rated

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Although not all staff were up to date with safeguarding training.

Not all nursing staff received up to date training specific for their role on how to recognise and report abuse. The compliance rate for training in safeguarding children at level three was 83%. This was lower that the trust's target completion rate of 90% due to long term absence of staff members through sickness or maternity leave.

The compliance rate for training in safeguarding adults' level two was 91% and met the trust target completion rate of 90%.

Staff knew how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Equality, diversity and human rights training formed part of the mandatory training programme. Staff could confidently identify patients with protected characteristics set out in legislation.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff had access to the trust's safeguarding policies which set out responsibilities of staff at all levels in safeguarding patients. The policies were within the review date and referenced national guidance and legislation. Staff had access to electronic records systems which highlighted alerts for safeguarding concerns.

Staff had access to the trust's chaperone policy, which set out staff responsibilities at all levels for chaperone processes including children. Staff told us that all children under the age of 16 had to attend with an adult. The service had experienced children turning up from beach without an adult which delayed access to the service.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff had access to support and guidance from the trust's safeguarding team if they had concerns about patients. Staff knew how to make a referral to the local authority if they identified safeguarding concerns.

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 were clean and had suitable furnishings which were clean and well-maintained. All of the areas we visited were visibly clean and free from clutter.

The service did not always perform well for cleanliness. We requested hand hygiene audits completed by the service, the audits received were for August 2021 to October 2021.The service did not meet the required level of hand hygiene in August and September where the compliance rate was 67% and 83% respectively. The service improved hand hygiene compliance which was recorded as 100% in October 2021.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff completed cleaning in line with cleaning schedules. We looked at the schedules which were completed at regular intervals.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff wearing appropriate PPE during patient care, including gloves, aprons and face masks. They disposed of these items correctly after patients contact and decontaminated their hands before and after patient contact. The service had hand sanitising gel for patient and staff use.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw staff clean all equipment after every use. Staff told us that this was standard practice to help reduce the incidence of infection.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The layout of the premises supported staff in managing patient care and the activities that took place. Staff had access to three side rooms and four bays. Each area was equipped with a wide range of suitable furniture and clinical equipment. For example, each area had a generous number of orthopaedic devices, such as wrist splints and shoulder slings. Staff could access trolleys with everything they needed to manage minor injuries, for example, sterile equipment and antiseptic solutions. Each bay area had privacy curtains that were clean and provided dignity for patients while they were being treated.

Clinical staff had a small nurse's station where they could always observe patients in the clinical area. The nurse's station was furnished with computers for administrative tasks, including access to patient records.

Staff carried out daily safety checks of all specialist equipment. Resuscitation trolleys were checked daily. All checks were completed using a handheld electronic device. We saw all checks were completed daily without any gaps. However, the electrical portable appliance testing had lapsed. The last testing was three months out of date. Leaders were aware and had plans for testing in place.

The service had enough suitable equipment to help them to safely care for patients. Staff had access to a wide range of equipment. For example, adult and paediatric pulse oximeters and blood pressure machines. Staff had access to investigations including swabs, pregnancy tests and urine dipstick and culture.

Staff could access diagnostics and x-ray facilities to increase assessment capability. However, access to the x-ray department was limited to a 10am start. This meant those attending at 8am had to wait if they needed to access the x-ray department.

Staff disposed of clinical waste safely. Staff used appropriate clinical and domestic waste bins which were segregated to avoid cross contamination. Sharps bins were signed, dated and stored correctly.

Assessing and responding to patient risk

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

Emergency nurse practitioners staffed the minor injuries unit. Emergency nurse practitioners had extended skills to assess and treat patients presenting with minor injuries. The unit had inclusion and exclusion policies in place which staff strictly adhered to. This meant that staff did not work beyond their skills, knowledge and experience.

Urgent and emergency services

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff completed clinical observations during the patient assessment process and had access to the national early warning score (NEWS2) observation charts if they had concerns about a patient. Staff used NEWS2 scores if an emergency ambulance was required to transfer a patient to the trust's emergency department in Norwich.

Reception staff recorded patient details and the reason for attendance upon a patient's arrival. There was a red flag list for reception staff to immediately notify nursing staff if patients presented with conditions such as chest pain, shortness of breath, abdominal pain, severe headache and collapse. These symptoms may indicate serious illness and present as a serious risk of deterioration. These conditions needed an immediate face to face, assessment to ascertain the level of intervention necessary. There was an emergency bell within reception that was used to gain an immediate response.

Staff completed assessments for each patient on arrival using a recognised method for the environment. Staff used a see and treat model of care which was recognised by The Royal College of Medicine. The system was for patients presenting with a minor illness or injury without further triage or assessment. Leaders told us the advantages of the system was patients were seen directly by a single, appropriately trained clinician. The clinician completed an episode of care for that patient. Staff followed associated protocols to ensure safeguards for those who required immediate attention.

Staff carried out brief nursing assessments to help decide levels of interventions, which included transfer to local hospitals. Staff understood the limitation of the department, such as, patients with chest pain or shortness of breath might deteriorate an emergency transfer to the local emergency department in Norwich. This meant that patients were transferred to the appropriate place for their care and treatment needs.

Staff were trained to use immediate life support in the event of an emergency. Two minor injuries unit staff had this training as well as a further 12 staff members from other departments. The hospital had a rota of staff who were responsible for coordinating a response to emergency calls.

Staff knew about and dealt with any specific risk issues. For example, staff saw a number of patients with burns. Staff carried out an initial assessment. If required, a referral was completed and guidance obtained as outlined in the burns network policy guidance. This allowed consistent management and continuity of care for these patients.

Staff shared key information to keep patients safe when handing over their care to others.

Staff completed patient details on to a shared system which allowed clinicians to escalate concerns across sites in a timely way and provide accurate handover information.

Nurse staffing

The service had enough nursing staff 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.

The service had enough nursing and support staff to keep patients safe. There were no staff vacancies. The matron told us that in the previous four weeks the unit was at least one nurse down per shift. Clinical staff worked in rotation at the unit and at the local emergency department. The unit employed one whole time equivalent matron**,** one whole time equivalent minor injuries emergency department matron, one whole time equivalent clinical educator, three whole time equivalent emergency nurse practitioners and one health care assistant who worked 12 hours per day.

Urgent and emergency services

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 workforce metrics were formally reviewed at the trust's bi-monthly workforce and education sub-board. Managers employed regular bank staff to provide additional staff support when needed. We looked at the health roster report and saw that from October 2021 to March 2022 the unit covered six shifts with bank staff. Staff sickness within the same period was 5.5%, the majority of which was COVID-19 related.

The department manager could adjust staffing levels daily according to the needs of patients. Nursing staff told us that managers pulled staff from the main emergency department to ensure appropriate levels of staffing at the unit. The unit could not open if it was not appropriately staffed.

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. Staff accessed patient notes using a secure, password protected shared electronic record system. All notes we looked at contained enough patient detail, including alerts and allergy indications required to help keep people safe. Staff could access imaging results, review and update care plans using the same system and share information with relevant staff.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff across the trust could access all patient records electronically using the shared system.

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.

Outcomes for patients were positive, consistent and met expectations, such as national standards. Leaders monitored performance against the key performance indicators. For example, if they met the national emergency department waiting times. The four-hour treatment standard was met from July 2021 to January 2022.

Patient average wait time to initial assessment in the period of November 2021 to January 2022 was 14 minutes. Patient arrival to departure was 129 minutes. Patients who were seen and waited on average 22 minutes for an initial assessment.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. We looked at the local audit programme and saw that hand hygiene audits were conducted for February, May, August and November 2021 which were undertaken by infection prevention control link nurses. Cleaning staff carried out cleaning audits monthly with a member of the clinical team. Clinical staff conducted resus trolley audits monthly in addition to daily checks using an electronic handheld system.

Managers used information from the audits to improve care and treatment. Staff carried out Methicillin-resistant Staphylococcus aureus (MRSA) audits and we saw the results were recorded and shared with staff via clinical governance meetings and minutes. We looked at the audit results for October 2021 and saw 100% compliance.

Managers shared and made sure staff understood information from the audits. Staff were sent minutes of meetings where audit data was discussed. We looked at the last three meeting minutes before our inspection. Membership and attendance at the clinical governance meeting included all key people. Attendees reviewed a dynamic action log, for example, incidents reported with actions for management and improvement. The agenda items were varied and included audit and research, workforce, mandatory training compliance, staff survey and ongoing training.

Leaders shared audit results and governance feedback with staff using various methods. Staff received a newsletter to keep them up to date with audit and governance updates. Departmental governance feedback included the nursing dashboard for performance.

Improvements were checked and monitored. Audits we looked at demonstrated improvements and good compliance. For example, hand hygiene data demonstrated an improvement with compliance with hand hygiene practices from August 2021 to October 2021. Saving lives audit compliance which was 100% and daily safety checks results were 100%.

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 worked across health care disciplines and with other agencies when required to care for patients. Staff liaised with different healthcare disciplines both internally within the trust and outside agencies. Minor injuries unit staff had regular contact with the trust's radiology department and the safeguarding team. Staff liaised with outside agencies, such as GPs, the local 111 service and social services when required.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. Staff were able to refer patients for a mental health assessment the mental health liaison team. Staff spoke about patient they had referred to the mental health liaison team and the support they had provided patients through this process.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support. We saw a wide range of patient leaflets available. For example, knee pain information leaflet, low back pain advice leaflet, neck pain leaflet, shoulder dislocation leaflet, soft tissue injury leaflet, access to your own fitness leaflet and head injury to child leaflet. Staff told us that discussed health promotion with patients during assessment and treatments to help prevent recurrence of injuries.

Urgent and emergency services

Staff provided information to patients about support groups and local agencies when required.

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 compassionate and respectful interactions between staff, patients, and their carers. Staff were observed as being kind in all interactions with people who attended the minor injuries unit. Patient satisfaction and experience results were displayed in the waiting area. Friends and family feedback for Cromer Minor Injuries Unit for February 2021 to February 2022 demonstrated an 89% response rate which was good.

Patients said staff treated them well and with kindness. One patient and their family member attended on the day of inspection with a box of chocolates and a thank you card for each member of staff with a private message thanking each of them for their caring and kind treatment. All patients and their carers we spoke with were positive about their experience and interactions at the unit. They reported being cared for with kindness and that staff had treated them well. We also saw this in all of our observations.

Staff followed policy to keep patient care and treatment confidential. All interactions were carefully considered with privacy and confidentiality in mind. For example, conversations between staff and patients were held privately to discuss confidential information. Clinicians ensured doors and curtains were closed to maintain confidentiality and dignity.

Is the service responsive?

Inspected but not rated

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit and treat patients were in line with national standards.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. The service had 7,134 attendances from July 2021 to January 2022, of these 3,004 (42%) were assessed within 15 minutes of arrival. Data provided by the trust demonstrated that 99.9% received treatment within the four-hour standard.

The number of patients leaving the service before being seen for treatments was low. Less than 1% (36) of patients left the unit before being seen for treatment, from July 2021 to January 2022.

Urgent and emergency services

Managers and staff worked to make sure patients did not stay longer than they needed to. Less than 1% (7) of attendances waited longer than four hours for treatment from July 2021 to January 2022.

Managers monitored patient transfers to the emergency department. Data provided by the trust showed that out of 7,314 attendances, nine patients were transferred to Norfolk and Norwich University Hospital from July 2021 to January 2022.

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. They supported staff to develop their skills and take on more senior roles.

The senior leadership team had oversight of the minor injuries unit. The minor injuries unit had a clear leadership structure and was overseen by the surgical nursing director, an emergency department medical governance lead, a surgical governance manager, and emergency department governance/risk facilitator supported by administrative support staff. The minor injuries unit staff worked closely with the emergency department and contributed to the major trauma centre planning initiative.

Leaders had the skills and abilities to run the service. Leaders were committed to safe patient care and supporting their staff. 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 the service.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff morale was good and there was a culture of working together for the benefit of the team and the people who used the service. All staff we spoke with were complimentary of each other and of their leadership team in terms of being a supportive culture and environment. Staff told us that they felt able to escalate concerns.

Staff were provided with support for development and learning for their role. We saw evidence of regular appraisals, revalidation, and support for continued professional and career development opportunities.

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. They had plans to cope with unexpected events.

Urgent and emergency services

The service had a risk register in place which identified the key risks. Leaders updated and regularly reviewed the service risk register with associated action plans. Local leaders shared risk information at monthly clinical governance meetings. We looked at meeting minutes and saw the top recorded risks were discussed. For example, we saw staff had discussed clinical capacity risks which stayed on the risk register for regular review. Staff also discussed the waiting area as an ongoing piece of work and discussions around triage of people in the waiting area.

The environment was not always suitable for the number of people who used the service. Leaders were aware of this, and clinical capacity risks stayed on the risk register for regular review. Staff discussed the possibility of patients having to queue within the glass atrium and outside the building because of capacity issues. Staff discussed and recorded these risks regularly and saw the increased negative impact on the patient experience and potential for untriaged patient health due to delay in contact with clinician. Leaders mitigated against risks and this was recorded and reviewed monthly.

Leaders attended a range of regular meetings to manage risks, performance, address issues and ensure actions were completed. We looked at a range of minutes of meetings where incidents, risks and audits were discussed. We looked at the previous three months emergency department risk oversight minutes, clinical governance minutes, team briefs, directorate governance minutes divisional governance meeting minutes. We saw staff discussed quality board key performance indicators, incidents and service risks.

The matron for the service and the emergency department governance team had oversight of all incidents and operated a strict process of escalation. All incidents were investigated involving key people. When other professionals were involved, such as ambulance and police, the external process of a quality improvement report was adopted and shared to quality improvements across services.

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:

Cromer Hospital - MIU

- The trust should ensure that staff complete training in safeguarding children level three in line with trust policy. (Regulation 18)
- The trust should ensure that the unit is suitably staffed at all times. (Regulation 18)