# The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

## Inspection report

Queen Elizabeth Hospital
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Date of inspection visit: 7th & 8th December 2021
and 11th & 12thJanuary 2022
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## Ratings

| Overall trust quality rating | Requires Improvement |
|---|---|
| Are services safe? | **Requires Improvement** |
| Are services effective? | **Good** |
| Are services caring? | **Good** |
| Are services responsive? | **Requires Improvement** |
| Are services well-led? | **Good** |

# Our findings

## Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

## Overall summary

**What we found**

### Overall trust

We carried out an unannounced inspection of three of the acute core services provided by this trust because the trust was in special measures. We carried out a comprehensive inspection of critical care and medical care and a focused inspection of urgent and emergency care services.

We also inspected the well-led key question for the trust overall.

We did not inspect several core services that had previously been rated as requires improvement because this inspection was focused on services where we had concerns. We are monitoring the progress of improvements to these services and will re-inspect them as appropriate. As we inspected three out of nine core services, this meant due to aggregation, the rating of requires improvement at location level would not have changed. Services previously rated as requires improvement and not inspected this time include:

- Surgery
- Maternity
- Gynaecology
- End of life care
- Outpatients
- Diagnostic Imaging

Our rating of this trust improved. We rated it as requires improvement and the chief inspector of hospitals has recommended to NHS England and NHS Improvement (NHSEI) that it be removed from the Recovery Support Programme.

- The trust has made marked improvement on those issues that led to it being placed in the Recovery Support Programme (which was then called Special Measures).

# Our findings

- We rated effective, caring and well-led as good, and safe and responsive as requires improvement. Well-led is the overall trust-wide rating, not an aggregation of services ratings.
- We rated all three of the services we inspected as good overall. In rating the trust, we took into account the current ratings of the seven services we did not inspect this time.
- Mandatory training, including safeguarding training compliance for medical staff was below the trust target. Staff did not consistently complete daily and weekly safety checks on resuscitation equipment. Critical care did not have a dedicated pharmacist to support the service. Patient records were not always stored securely. The service did not always use systems and processes to safely prescribe, administer, record and store medicines.
- People could not always access the services when they needed it. Waiting times from referral to treatment were not always in line with national standards.

However:

- Most services had enough staff to care for patients and keep them safe. Staff had training in key skills, 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. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make 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, and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

**How we carried out the inspection**

We carried out this inspection on various days throughout December 2021 and January 2022. We visited areas relevant to each of the core services inspected and spoke with a number of patients and staff, as well as holding focus groups. During the inspection we visited critical care, all ward areas for medical services except Stanhoe ward as patients with COVID-19 were being treated on this ward, and all areas of the adult and children's emergency department, except those restricted due to COVID-19 for urgent and emergency care. We spoke with 76 staff members of various specialty and profession including, consultants, doctors, nurses, healthcare support workers, pharmacists, domestic staff, therapists, support staff, governance and educational staff and senior managers. We spoke with 13 patients throughout the departments and reviewed 36 patient records.

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

## Outstanding practice

We found the following outstanding practice:

**Critical Care**

- The service had an embedded succession planning programme for band 5 nurses, which gave them the opportunity to develop leadership skills on a rotational basis preparing them for future leadership roles.
- The service was dedicated to improving patient safety and experience through innovation and research. Staff were encouraged and enabled to develop research projects with ownership to findings.

## 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**:

We told the trust that it must take action to bring services into line with two legal requirements. This action related to two services.

**Urgent and Emergency Care**

- The service must ensure that care and treatment are accessible at the time of need and referral to treatment times and waiting times are in line with national standards (Regulation 12).

**Medical Care**

- The trust must ensure daily and weekly checks on resuscitation equipment is maintained in line with trust guidance (Regulation 12).
- The trust must ensure patient records are stored securely (Regulation 17).
- The trust must ensure medicines are stored and managed appropriately (Regulation 12).

**Action the trust SHOULD take to improve:**

**Urgent and Emergency Care**

- The service should ensure all medical staff complete appropriate levels of safeguarding training for adults and children (Regulation 18).
- The service should ensure staff carry out checks on specialist equipment and record this in line with service guidance (Regulation 12).
- The service should ensure when antibiotics are prescribed on admission, staff record a reason for this to promote best practice for antimicrobial stewardship and ensure antibiotics are being used appropriately (Regulation 12).

# Our findings

- The service should continue to explore opportunities to improve its physical environment, especially for children, the treatment of minor injuries and streaming services.
- The service should continue its recruitment to employ additional medical staff in response to the increased patient numbers and demands within the service.

**Medical Care**

- The service should ensure mandatory and safeguarding training amongst medical staff is completed in line with trust targets (Regulation 12).
- The service should ensure people can access the service when they need it (Regulation 12).

**Critical Care**

- The service should ensure that doctors mandatory training compliance is in line with the trust targets (Regulation 18).
- The service should ensure there is a dedicated pharmacist to support the service (Regulation 18).

## Is this organisation well-led?

Our rating of well-led improved. We rated it as good.

Leadership

**Leaders had the skills and abilities to run the trust. They understood the priorities and issues the trust faced. They were visible and approachable throughout the trust for patients and staff. They supported staff to develop their skills and take on more senior roles.**

- The leadership team, including non-executive directors, had the capacity and capability to deliver high-quality services. Through the leadership of the executive and non-executive team, significant improvements were noted throughout our inspection regarding culture and a focus on patient safety. We heard from staff how leaders were visible and had a clear focus on embedding improvements that were sustainable.
- Leadership programmes were in place to support the development of the senior leadership team, as well as divisional leadership teams. This supported the team to enable sustainability of improvements and allowed for succession planning.
- Staff we spoke with during the core service inspection told us how approachable the leadership team was and spoke highly of the changes made under the leadership team.
- We reviewed five personnel files in line with Fit and Proper Persons Requirement: Directors (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014 and found appropriate employment checks had been made.
- Executive and non-executive directors were also required to complete an annual self-declaration, to confirm they did not fall into the definition of an “unfit person” or any other criteria set out in the guidance. We reviewed evidence to confirm this was completed.

Vision and Strategy

# Our findings

**The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**

- The trust had a vision for what it wanted to achieve and a strategy which aligned to the vision which was developed with patients, staff, volunteers, governors and external stakeholders.
- The strategy had three domains: quality, engagement and healthy lives which shaped six strategic objectives, two within each domain. These also demonstrated how the strategy was aligned to local plans within the wider health economy including the Norfolk and Waveney system strategy, as well as collaborative working with local acute hospitals, primary care providers, community providers, mental health providers and social care.
- Corporate and divisional workplans were in place to underpin the strategy. Workplans included milestones of delivery which were monitored on a quarterly basis.
- The trusts estates and facilities workplan included plans to maintain safety of the roof structure, which was linked to one of the trusts strategic objectives and strategic risk register.
- The leadership team were clear of the importance of measurable outcomes and monitoring evidence of impact which was then cascaded throughout the organisation. Executive and non-executive directors spoke clearly of potential risks that impacted on the delivery of the strategy and had given thought how to mitigate risk.
- A trust wide pharmacy strategy had been in place which expired in 2021. However, the trust were working with other providers within the integrated care system to develop a system wide medicines optimisation strategy. Priorities included antimicrobial stewardship, bio-similar switches, digitalisation and workforce.

Culture

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

- Staff felt respected, supported and valued by the leadership team. Staff, including the leadership team, described an open and honest culture whereby people were encouraged to be brave and speak out against inappropriate behaviours.
- The leadership team had made good progress to improve organisational culture and could describe the areas where culture still needed to be developed and spoke of improvement plans that were in place.
- We heard how some staff felt middle management did not always take concerns seriously. However, staff knew if concerns were raised through the freedom to speak up function, executive scrutiny would be held, and they felt assured action would be taken. This level of confidence was not consistent at middle management level.
- Leaders spoke fluently about the need to be kind, fair and to have regard to individual wellness. An extensive staff engagement programme had been put in place to maintain wellbeing of staff recognising the impact the COVID-19 pandemic had on staff and their emotional resilience.
- The trust promoted an open culture, so patients, their families and staff could raise concerns without fear and be involved in all aspects of care. Policies were in place to support raising concerns.

# Our findings

- Senior leaders identified poor staff performance promptly and took relevant action. The Director of People spoke about being people driven and having a focus on management of learning and development which enhanced the wellbeing agenda and focus on supporting staff to stay well in work. This was in the early stages of development.
- The trust promoted equality and diversity in daily work and provided opportunities for career development. Plans were in place to work with the regional talent network and to pilot this within pharmacy department which focused on clear development plans and retention. There was recognition that although work had commenced, more was required, to create more diverse leaders throughout the organisation. Pastoral care was in place for staff members who had travelled from overseas and plans were in place to create bespoke packages of development to enhance resilience and confidence to apply for promotions.
- As a result of the workforce race equality standard, the trust had implemented various actions. This included a requirement to have a black, Asian, minority ethnic representative, gender representative and human resources representative on selection and interview panels at band 7 and above. As part of the trusts' culture transformation programme, recruiting with values was introduced which included inclusion of equality, diversity and inclusion questions within all interviews. Values into actions and leading with values was also introduced and to date 30% of staff had attended the sessions which had an emphasis on zero tolerance to bullying, harassment and discrimination in any form.
- The trust's lead Freedom to Speak Up Guardian reported themes of concerns to the board of directors. From April to September 2021, 32 referrals had been received by the Freedom to Speak Up Guardian, themes were regarding workplace culture mainly relating to attitudes and behaviours. Clear actions and objectives were in place for the remainder of the financial year.
- Junior doctors now felt able to raise concerns regarding their work with management teams. Themes were reviewed and reported to the board of directors by the guardian of safe working hours.
- We reviewed 10 serious incident investigations and noted the investigations were thorough and evidenced duty of candour had been applied. Although we did note for one of the incidents, duty of candour had been applied four months after the incident which was not in line with the regulation for duty of candour.

Governance

**Leaders operated effective governance processes, throughout the trust and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of services.**

- Leaders operated effective governance processes, through the trust and with partner organisations. Staff were clear about their roles and responsibilities.
- Governance processes in place ensured there were opportunities to discuss and learn from the performance of services, including reviewing actions taken to mitigate risk.
- Non-executive directors were able to review performance information and scrutinise data which enabled open discussions with executive colleagues.
- The board assurance framework was aligned to the six strategic objectives and links were evident to the significant risk register. There was an executive lead for each of the strategic objectives who were responsible for providing monthly and quarterly updates on the delivery of the objectives with evidence of impact, as well as mitigating actions whereby the objective was not on track to be delivered.

# Our findings

- The internal audit annual report highlighted the number of reviews completed throughout 2020/21 and presented to the audit committee. All recommendations had been accepted by the trust board. It recognised initially progress against the recommendations had been slow, however pace had improved since January 2021. Where assurance was still required to improve governance processes, the trust had action plans in place which were included within corporate and divisional workplans.
- Divisional leadership teams and corporate service leads were required to present to performance review meetings which included quality to enhance monitoring and accountability. Divisional governance managers supported divisions to monitor quality indicators. Integrated performance quality reports at divisional level replicated board level reports.
- The medicines forum group reported to the clinical governance meeting and provided assurance of compliance with medicines guidance and policy across the trust.

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. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**

- Arrangements were in place to identify, record and manage risk, issues and mitigating actions.
- The significant risk register clearly described the risk, what it related to and an updated commentary on actions being taken. Risks were also aligned to the strategic objectives. Divisions were required to review significant risks on a monthly basis which were reported through the assurance and risk executive group before being reported to the board of directors.
- The trust identified and escalated risks and issues and identified actions to reduce their impact. Divisions monitored medium risks on a quarterly basis at divisional board meetings, where a risk increased in their risk rating, a monthly update was required at the assurance and risk executive group.
- The trust's most substantial risk was the safety of the roof structure. Both the executive and non-executive directors spoke eloquently about this and were focused on managing it while seeking long term solutions to the estate problems.
- There was a positive incident reporting culture. Staff told us they were encouraged to report and learn from incidents which we saw within our core service inspections.
- Medicines incidents were investigated within divisions and the medicines forum examined trends and areas of concern. The medicine safety officer (MSO) also reviewed all medicines incidents and conducted regional benchmarking and found incident reporting was comparative across the regions acute trusts.
- The learning from deaths process was established and the reporting structure was adhered to. This included contributing to learning from deaths of people with a learning disability (LeDeR).
- Plans were in place to ensure the trust could cope with unexpected events.
- The trust had strengthened its financial position significantly over the last couple of years. A financial strategy was in place which encouraged everyone to deliver efficiently and efficiency programmes were approved by executive and non-executive directors. The leadership team were acutely aware to maintain long-term sustainability a focus was required on integrated care system working and place based care.

Information Management

# Our findings

**The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**

- The trust used statistical process controls to understand performance, make decisions and improvements. These were presented within an integrated performance report and presented to the board of directors on a monthly basis. Reporting included a wide range of performance indicators and summarised the key issues, key actions and key risks to forecast improvement.
- The Caldicott function worked closely with the senior information risk owner (SIRO) and processes were in place to ensure data was protected.
- Following a no assurance report into cyber security, the trust implemented immediate actions and included actions for monitoring through an integrated quality improvement plan programme. This had led to a recent recruitment of a Head of Cyber who had developed improvements further with minimal outstanding actions for completion.
- Information governance incidents were discussed at the serious incident group and if appropriate reported to the Information Commissioners Office.
- An electronic prescribing and medicines administration system (EPMA) had been rolled out across medical and surgical divisions. There was a plan in to roll it out to remaining areas, including in the Emergency Department and paediatrics. Some elements of prescribing remained on a paper-based system.

Engagement

**Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

- The trust engaged with patients, staff, equality groups, the public and local organisations to plan and local organisations to plan and manage services.
- The trust had a clear plan for internal and external engagement. Systems and process were in place to gauge how people felt in real time.
- Two of the six strategic objectives within the trusts' strategy focused on engagement. One was to strengthen staff engagement to create an open culture with trust at the centre. The other was to work with patients and system partners to improve patient pathways and ensure future financial and clinical sustainability.
- The council of governors noted there was an emphasis on change in culture and support for all staff from the leadership team. We also heard how patients had more confidence in the trust which was seen through discussions at the patient participation group. The council of governors felt listened to, able to give their views and effectively challenge and hold the non-executive directors to account.
- We heard how communication, inclusion and partnership working were some of the biggest improvements within the trust.
- The pharmacy team sought direct patient feedback from patients receiving chemotherapy on the Macmillan day unit. This led to improvements in communication and the availability of blood results, so chemotherapy was always made up ahead of time and available for administration at the time of the patient's appointment.

# Our findings

- The chief pharmacist had regular meetings with pharmaceutical leaders from local acute trusts within the integrated care system and was also a member of the Pharmacy Eastern Network. Other members of the pharmacy team worked closely with the Norfolk therapeutics advisory group and the local clinical commissioning group. The chief pharmacist was also the Controlled Drugs Accountable Officer and attended the controlled drugs link meetings.
- The most recent Friends and Family Test (FFT) results for the trust showed a level of satisfaction which ranged from 80% in the emergency department to 100% in maternity. Themes from the FFT results were reviewed and highlighted poor communication as the main theme. The trust had introduced family liaison officers as a result and reviewed the impact noting they received around 1,000 contacts per week. As a result, the number of formal complaints had reduced.

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 and participation in research.**

- There was strong focus on quality improvement to improve patients care and outcomes. The leadership team described an emphasis on a quality improvement culture and encouraged research.
- The trust was committed to improving services by learning from when things went well, and when they went wrong. For example, the trust had carried out a duty of candour exercise to contact families and patients who had contracted COVID-19 as a result of their inpatient stay.
- Leaders were aware of improvements made as a result of serious incidents and complaints. Evidence of actions were required to demonstrate impact at the evidence assurance group. This was evident through the introduction of patient safety newsletters, safety alerts and quarterly patient safety learning events for all trust staff and external stakeholders to attend.
- Those leading on root cause analysis investigations had received relevant training to ensure incidents were investigated thoroughly and actions identified.
- From September 2021 to November 2021, the trust received 15 complaints across all services. A theme from complaints and friends and family tests included concerns around communication and behaviour. As a result, family liaison officers were introduced and a notable decrease in the number of complaints had been seen across the trust. This was a national first and has since been rolled out across the Norfolk and Waveney system.
- We reviewed 10 complaints and noted all were investigated and responded to in line with the trust policy.
- From September 2021 to November 2021, the trust received 415 compliments across all services. A breakdown of the compliments was disseminated to ward and departmental areas to share good practice. Individuals could also request to use compliments as part of their appraisal and revalidation which provided an opportunity to reflect on positive practice.

## Key to tables

| Ratings | Not rated | Inadequate | Requires improvement | Good | Outstanding |
|---|---|---|---|---|---|
| Rating change since last inspection | Same | Up one rating | Up two ratings | Down one rating | Down two ratings |
| Symbol * | ➔➔ | ↑ | ↑↑ | ↓ | ↓↓ |

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

### Ratings for the whole trust

| Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|
| Requires Improvement ↑ Feb 2022 | Good ↑↑ Feb 2022 | Good ↑ Feb 2022 | Requires Improvement ➔➔ Feb 2022 | Good ↑↑ Feb 2022 | Requires Improvement ↑ Feb 2022 |

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

## Rating for acute services/acute trust

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| The Queen Elizabeth Hospital | Requires Improvement ↑ Feb 2022 | Good ↑↑ Feb 2022 | Good ↑ Feb 2022 | Requires Improvement →← Feb 2022 | Requires Improvement ↑ Feb 2022 | Requires Improvement ↑ Feb 2022 |
| Overall trust | Requires Improvement ↑ Feb 2022 | Good ↑↑ Feb 2022 | Good ↑ Feb 2022 | Requires Improvement →← Feb 2022 | Good ↑↑ Feb 2022 | Requires Improvement ↑ Feb 2022 |

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

## Rating for The Queen Elizabeth Hospital

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Medical care (including older people's care) | Requires Improvement ↓ Feb 2022 | Good ↑ Feb 2022 | Good → ← Feb 2022 | Good ↑ Feb 2022 | Good ↑ Feb 2022 | Good ↑ Feb 2022 |
| Services for children & young people | Good Jul 2019 | Good Jul 2019 | Good Jul 2019 | Good Jul 2019 | Requires improvement Jul 2019 | Good Jul 2019 |
| Critical care | Good → ← Feb 2022 | Good → ← Feb 2022 | Good → ← Feb 2022 | Good → ← Feb 2022 | Outstanding ↑ Feb 2022 | Good → ← Feb 2022 |
| End of life care | Good Dec 2020 | Requires improvement Dec 2020 | Good Dec 2020 | Requires improvement Dec 2020 | Requires improvement Dec 2020 | Requires improvement Dec 2020 |
| Surgery | Good Dec 2020 | Good Jul 2019 | Good Jul 2019 | Requires improvement Jul 2019 | Requires improvement Dec 2020 | Requires improvement Dec 2020 |
| Urgent and emergency services | Good ↑ Feb 2022 | Good ↑ Feb 2022 | Not rated | Requires Improvement → ← Feb 2022 | Good ↑ Feb 2022 | Good ↑ Feb 2022 |
| Diagnostic imaging | Requires improvement Dec 2020 | Not rated | Good Jul 2019 | Requires improvement Jul 2019 | Requires improvement Dec 2020 | Requires improvement Dec 2020 |
| Maternity | Requires improvement Dec 2020 | Good Jul 2019 | Good Jul 2019 | Good Jul 2019 | Requires improvement Dec 2020 | Requires improvement Dec 2020 |
| Outpatients | Good Jul 2019 | Not rated | Good Jul 2019 | Requires improvement Jul 2019 | Requires improvement Jul 2019 | Requires improvement Jul 2019 |
| Gynaecology | Requires improvement Jul 2019 | Good Jul 2019 | Good Jul 2019 | Requires improvement Jul 2019 | Requires improvement Jul 2019 | Requires improvement Jul 2019 |
| **Overall** | Requires Improvement ↑ Feb 2022 | Good ↑↑ Feb 2022 | Good ↑ Feb 2022 | Requires Improvement → ← Feb 2022 | Requires Improvement ↑ Feb 2022 | Requires Improvement ↑ Feb 2022 |

# The Queen Elizabeth Hospital

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## Description of this hospital

The Queen Elizabeth Hospital King's Lynn is an established 533 bed (consultant led, including adult and children and all level one care. Excluding critical care level 2 and 3 beds) general hospital on the outskirts of King's Lynn, Norfolk. It provides healthcare services to West and North Norfolk in addition to parts of Breckland, Cambridgeshire and South Lincolnshire. The trust achieved Foundation Trust status in 2011 and is part of the Norfolk and Waveney Integrated Care System (ICS). The trust is commissioned by clinical commissioning groups from three counties. The lead commissioner is Norfolk and Waveney Clinical Commissioning Group. The local population of this area is approximately 331,000 people which includes a high proportion of older residents; however, new housing developments in recent years have seen large population growth of principally young families. The trust provides a comprehensive range of specialist, acute, obstetrics and community-based services. The trust works with neighbouring hospitals for the provision of tertiary services and is part of regional partnership and network models of care, such as the trauma network. Some specialist services and clinics were provided in community facilities, such as the North Cambridgeshire hospital in Wisbech.

Trust activity:

Between July 2020 and June 2021 there were:

- 55,472 inpatient admissions
- 245,616 outpatient appointments
- 68,181 A&E attendances
- 1,238 deaths

# Medical care (including older people's care)

**Good** ↑

## Is the service safe?

**Requires Improvement** ↓

Our rating of safe went down. We rated it as requires improvement.

### Mandatory Training

**The service provided mandatory training in key skills to all staff; however, not all medical staff had completed it.**

Nursing staff received and kept up to date with their mandatory training. Data supplied by the trust following our inspection showed nursing staff achieved above the trust's 80% compliance target. This was an improvement since our last inspection. However, medical staff failed to achieve 80% compliance for mandatory training which was an area of poor compliance identified at our last inspection. Mandatory training compliance was exacerbated by the pressures of the COVID-19 pandemic. However, we saw evidence of action plans to address poor compliance with mandatory training, including increasing the use of e-learning to allow for training to be completed remotely.

The mandatory training programme was comprehensive and met the needs of patients and staff. Training was provided through a combination of e-learning and face-to-face sessions. This was tailored to the skill requirement of staff and was dependent on their role. Topics included, but were not limited to, mental capacity; equality, diversity and human rights; fire safety; infection prevention and control; and safeguarding.

Clinical staff completed training on recognising and responding to patients living with learning disabilities and dementia. Nursing staff completed learning disabilities, autism and dementia training through workbooks. Staff could also undertake elearning or face to face training on dementia and a dedicated session had also been provided as part of the junior doctor weekly training programme.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training records were centralised, ward managers had oversight of staff training records and knew when staff required refresher training.

Staff within the service understood their responsibility to complete training and told us training was relevant to their roles. New staff we spoke with said the trust provided ongoing support and guidance and that induction training met their needs.

### Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, not all medical staff were up to date with their training.**

There were clear systems, processes and practices to safeguard patients from avoidable harm, abuse and neglect that reflected legislation and local requirements. Safeguarding adults and children policies were in-date and accessible to all staff.

# Medical care (including older people's care)

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we spoke with demonstrated a good understanding of their responsibilities in relation to safeguarding adults in vulnerable circumstances and gave examples of the type of abuse they may see, for example domestic violence, female genital mutilation (FGM) and financial abuse. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff we spoke with demonstrated a good understanding of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Nursing and medical staff received training at the correct level specific for their role on how to recognise and report abuse. Data provided by the trust following our inspection showed nursing staff achieved 95% compliance with safeguarding adults training and medical staff achieved 71%. Similarly, nursing staff achieved 94% compliance with children's safeguarding training and medical staff achieved 65%. Medical staff were below the trust compliance target of 80% for both adults and children's safeguarding training. This was an area of poor compliance at our last inspection.

There was a named safeguarding lead for adults and children at the trust, in addition to named doctors for vulnerable adults and women. Staff who we spoke to were aware of who they were, and contact details were displayed on posters. The safeguarding leads were available to provide advice and support to staff on any safeguarding related matter.

Staff followed safe procedures for children visiting. Wards were protected by buzzer and locked door systems to prevent non-authorised entry.

Safety was promoted through recruitment procedures and employment checks. Staff had Disclosure and Barring Service (DBS) checks completed before they could work. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

### 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.**

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Staff followed infection control principles, including the correct use of personal protective equipment (PPE) such as disposable gloves and aprons. PPE was readily available in all clinical areas.

Staff adhered to 'bare below the elbows' principles to enable effective hand washing and reduce the risk of spreading infections. Hand sanitising units and handwashing facilities were available in all areas and handwashing prompts were visible for staff, patients and the public.

All areas were visibly clean and had suitable furnishings which were clean and well-maintained. All equipment and treatment rooms were cleaned between patients, and equipment was labelled as having been cleaned which was good practice. Cleaning was carried out against schedules and cleaning records reviewed were up to date and demonstrated that all areas were cleaned regularly. Curtains were disposable and staff had recorded the date they were put up and all were visibly clean.

# Medical care (including older people's care)

The service performed well for cleanliness. There were effective systems to ensure standards of hygiene and cleanliness were maintained. Standards of cleanliness were regularly monitored, and results were used to improve infection prevention control (IPC) practices where needed. There was a regular programme of IPC audits to ensure good practice was embedded in all areas. Staff displayed cleaning and environmental audit compliance data on a white board visible to staff and patients and their families.

Monthly IPC audits were completed within the service. The audits included, but were not limited to, hand hygiene compliance and environmental/perfect ward compliance. Data from September 2021 to November 2021 showed that most medical wards scored 100% in the monthly hand hygiene audit.

Staff screened patients for MRSA and Clostridioides difficile (*C.difficile*) on admission and if they developed symptoms. All the patient care records we reviewed evidenced staff had screened patients appropriately.

From June 2020 to October 2020, the trust reported 10 *C.difficile* infections in the medicine division. There were no MRSA bacteraemia reported in the same period. MRSA is a type of bacteria that is resistant to a number of widely used antibiotics.

Patients with infections were nursed in side rooms with appropriate signage displayed to reduce the risk of spreading infection. Deep cleans were arranged following the discharge of patients with an infection. There were apron and glove stations near to all side rooms to ensure that both patients, relatives and staff were protected.

The trust had identified ward areas specifically for the care and treatment of COVID-19 positive patients, these were separate areas and had additional controls regarding PPE and infection control.

The endoscopy department had achieved accreditation with the Joint Advisory Group (JAG) for endoscopy. This indicated there were appropriate procedures in place for the decontamination of instruments and endoscopes and traceability of items used for the procedure.

There were processes in place for clinical waste management. Clinical waste bins were foot operated and once bags were full, they were removed to a secured waste area. Waste was separated into different coloured bags to signify the different categories of waste. This was in accordance with the health technical memorandum (HTM) 07-01, control of substance hazardous to health (COSHH), health, and safety at work regulations. All sharp boxes we observed were correctly assembled, labelled, and dated. None of the bins were more than half-full, which reduced the risk of needle-stick injury. This is in accordance with HTM 07-01: safe management of healthcare waste. All sharp bins had temporary closures in place. Temporary closures are recommended to prevent accidental spillage of sharps if the bin was knocked over and to minimise the risk of needle-stick injuries.

### 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. However, daily safety checks on resuscitation equipment were not consistently completed.**

Patients could reach call bells and staff responded quickly when called. We observed staff ensuring patients had call bells within reach as well as other equipment, for example walking aids. Patients we spoke with told us staff responded to them quickly.

The design of the environment followed national guidance. The environment was designed and managed to ensure the safety of patients using them. All wards were easily accessed and signposted from the main entrance. All wards we inspected were arranged to ensure separate male and female bays, with separate toilet and washing facilities allocated to each bay.

Security arrangements were adequate to prevent vulnerable patients leaving the building. Staff gained access to wards and clinical areas with electronic swipe cards. Visitors gained access using a call bell, which enabled staff to monitor visitors and patients entering the wards.

Staff generally carried out daily safety checks of specialist equipment. Resuscitation equipment, for use in an emergency, was easily accessible and were available on each ward and clinical areas. There were tamper proof tags on the drawers used to store some of the equipment. Staff checked equipment on the top of the trolley daily and also checked that the tamper proof tags were undisturbed. Checks were recorded electronically and there were robust arrangements to monitor compliance. Data provided following our inspection showed from September 2021 to November 2021, compliance with daily checks varied between 63% and 100% across all medical wards. The average compliance for September, October and November 2021 was 92%; 94%; and 93% respectively. Compliance with resuscitation equipment checks was an area identified as a concern at our last inspection. Information submitted by the trust showed a number of actions were taken to address poor compliance, including missed check alerts sent to managers and matrons, and each missed check followed up locally with support from the resuscitation team.

Piped oxygen and suction equipment was available at each bed space, as well as emergency call buttons.

The maintenance and use of equipment kept patients safe. Electrical appliances and equipment we checked during the inspection had been tested and serviced to ensure they were safe to use and had stickers with appropriate dates to show that this had taken place. We checked 46 pieces of equipment and the majority were in date.

The endoscopy service was accredited with the Joint Advisory Group on Gastrointestinal Endoscopy (JAG). JAG is an accreditation scheme that is awarded to endoscopy services following a peer review of standards, including standards of environment and equipment. JAG awarded a trust with accreditation upon the achievement of a framework of requirements supporting the assessment of endoscopy services and achievement of person-centred care.

Staff managed clinical waste well. Waste management was handled appropriately with separate colour coded arrangements for general waste and clinical waste. Sharps, such as needles, were disposed of correctly in line with national guidance. Arrangements for control of substances hazardous to health (COSHH) were adhered to. Cleaning equipment was stored securely in locked cupboards.

### 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.**

Appropriate systems were in place to assess risk, recognise and respond to deteriorating patients within the service. Systems were in place to appropriately assess and manage patients with mental health concerns.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The service used the national early warning score 2 (NEWS2) system. NEWS2 is a point system tool used to standardise the approach to detecting deterioration in a patient's clinical condition. The NEWS2 was calculated and recorded on a paper-based system. The generated NEWS2 score provided a prompt to the staff entering the data, to review if the patient was unwell

and/or deteriorating and required a medical review. However, within Endoscopy the NEWS2 scoring was not used. Information received from the trust following our inspection showed all patients' vital signs were routinely monitored and recorded on a standardised observation chart for patients undergoing endoscopy. This was completed alongside the Leeds Sedation Score and due to the nature of the procedure, patients were under constant observation. The Endoscopy Unit were always staffed adequately, and registered staff had all attended basic and immediate life support training. In addition, support staff had undergone training to recognise signs of patient deterioration. Staff were also trained in the NEWS2 scoring system. The escalation of a deteriorating patient process was displayed within the recovery area, along with the details of the Critical Care Outreach Team. The Endoscopy Unit also had senior medical cover presence within the department during the endoscopy lists, who were able respond to any concerns raised by the recovery team. The trust provided assurance that there had been no serious incidents raised regarding failure to escalate and any adverse events were monitored as part of their JAG accreditation status and presented as part of a routine six monthly audit cycle within the Endoscopy Unit.

Staff knew about and dealt with any specific risk issues. There was a clear pathway for the management of sepsis. Sepsis is a potentially life-threatening illness when the body's response to infection injures its own tissues and organs. Early recognition and prompt treatment have been shown to significantly improve patient outcomes. Nursing and medical staff confidently described the signs of and what treatment should be initiated in line with national and local guidance. This included completing the 'Sepsis Six' pathway and immediate escalation to medical staff. Sepsis six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. All staff we spoke with knew how to escalate deteriorating patients and understood the importance of doing this in a timely manner.

Staff had 24-hour access to onsite critical care for patients who required additional one to one care for invasive intensive interventions.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly. Medical staff completed an initial admission assessment for patients, that included their presenting problem, past medical history and physical assessment. Comprehensive risk assessments were carried out for patients and risk management plans were developed in line with national guidance. We reviewed 20 sets of patient records and found all were completed, legible and risks were monitored routinely.

Further risk assessments were undertaken for venous thromboembolism, falls, malnutrition and pressure ulcers. These were documented in patient records and included actions to mitigate any identified risks. The trust used the malnutrition universal screening tool (MUST) to identify patients, who were malnourished, at risk of malnutrition or obese. We observed that patients identified at risk had a care plan in place and were monitored more frequently by staff to reduce the risk of harm.

Data provided by the trust following our inspection showed compliance with completing venous thromboembolism (VTE) risk assessments within medicine as at September 2021 was 98%. All the records we reviewed during our inspection had the relevant VTE risk assessments completed.

The trust had a dedicated falls prevention nurse and tissue viability nurse and staff followed up to date guidance to complete falls and pressure care assessments. Patients that were at high risk of falls and pressure ulcers had additional safety measures in place, including enhanced observations.

Ward staff carried out intentional care rounding checks at least every two hours on all patients to document that comfort and care needs were met. Records we reviewed showed that these checks had been completed and recorded.

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 knew how to contact the mental health team when required and were aware this was a 24-hour service.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff described how they would access the mental health team should they have any concerns, and there was a timely response to assess patients.

Staff shared key information to keep patients safe when handing over their care to others. We saw that safety briefings occurred in all areas at least once a day. Safety briefings included discussion around staffing and skill mix. Appropriate actions were taken following the safety briefing and concerns escalated to senior staff.

All staff participated in ward and board handovers where key information was shared at regular intervals throughout the day. This information included discharge planning, the patient's current wellbeing, any safeguarding issues, ongoing clinical needs and additional key information appropriate to the patients care.

Shift changes and handovers included all necessary key information to keep patients safe. Nursing staff on wards held a handover when staffing changed. This included all relevant information on patients' needs. We observed handovers between the day teams and night teams and found shift changes and handovers included all necessary key information to keep patients safe.

### Nurse staffing

**The service generally had 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 and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.**

The service generally had enough nursing and support staff to keep patients safe when we visited, but staff reported of being overstretched if their colleagues were absent due to sickness or leave. Staffing pressures were exacerbated by the pressures of the COVID-19 pandemic. The number of nurses and healthcare assistants mainly matched the planned numbers, and local leaders reviewed the staffing on each ward at least three times a day with escalation and mitigation processes in place.

The wards we visited displayed daily the staffing requirement for both registered nurses and healthcare assistants for both day and night shifts. Overall, there seemed to be sufficient staff within most areas visited at the time of the inspection, with mitigation in place for areas of shortfall such as agency staff, bank staff and re-deployment of staff to other wards.

Managers accurately calculated and reviewed the number and grade of nurses, and healthcare assistants needed for each shift in accordance with national guidance. The trust used a safer staffing bundle to monitor staffing levels and ensured that staff were delegated appropriately across the service. Daily meetings enabled the staff team to identify any areas where staffing shortfalls occurred, and managers delegated staff accordingly.

The ward manager could adjust staffing levels daily according to the needs of patients. There was an established escalation and mitigation procedure in place for the ward managers to raise staffing issues and concerns. The trust used a safe staffing tool, which considered nursing activity as well as patient dependency. This enabled senior nursing staff to identify areas with staffing pressures and allocate staffing across the organisation.

The service used bank and agency staff to meet planned staffing numbers. Internal bank staff were offered unfilled shifts to ensure staffing establishment was met. Staff told us that the bank staff used were generally the same staff and were known to the service. Managers made sure all bank and agency staff had a full induction and understood the service.

From data the trust submitted, the service had a nursing vacancy rate of 158 whole time equivalent (WTE), predominantly non-registered nurses. These were offset by the use of bank and agency staff. Funded establishment had been identified for Feltwell and Levington wards, in addition to 54 international nurses who had recently started in November 2021. A further bid had been submitted across the integrated care system for an additional 64 nurses to arrive in 2022 for across all areas of the trust.

The service had a sickness rate as at 31 October 2021 of 8.1% against the trust target of 4.5%. Sickness was monitored at divisional level, as well as by ward managers. A number of actions were taken to address sickness, including specific individual plans established for return to work, fast track referral processes, and long COVID clinics.

There were effective nursing handovers at shift change times. Nursing staff were allocated to care for specific bays, side rooms, or patients who needed one to one care. Each nurse handed over their patients to the specific nurse taking over that area and the nurse in charge had a handover of the whole department. Senior staff provided an overview of all the patients on the ward and highlighted any issues for staff to be aware of. Each staff member was able to access information detailing patient clinical history and updated treatment plans. The nurse handing over discussed each patient, how the patient had been and what changes had occurred. Handovers were concise and gave oncoming staff a clear description of what each patient required.

### Medical staffing

**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. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.**

The service had enough medical staff to keep patients safe. Medical staffing was appropriate with effective out of hours and weekend cover. Rotas were planned to ensure adequate numbers, and medical staff we spoke with told us there were sufficient staffing levels and a willingness for staff to cover each other at times of absence or due to holidays and training.

Most wards had two dedicated consultants who were responsible for patients' treatment. The number of specialty consultants varied according to the specialty and ward size. Each consultant team had a registrar and junior doctors. Junior doctors were easily contacted and responded in a timely manner. All patients were seen by medical staff on a daily basis.

The service always had a consultant on call during evenings and weekends. Out of hours, on call consultants were contactable and a defined rota was in place. Medical cover overnight consisted of a team of registrars and junior doctors' who were responsible for inpatient areas.

In July 2021, the proportion of consultant staff and registrar group reported to be working at the trust was slightly lower than the England average, and the proportion of junior (foundation year 1-2) staff was higher than the England average. Data submitted by the trust following our inspection showed there were 17 vacant consultant posts and 11 vacant middle grade posts. However, this was offset by the use of medical agency staff.

# Medical care (including older people's care)

All medical staff we spoke with said they received a good level of support from their consultants who were approachable and able to be contacted at any time. Junior doctors reported they had been allocated an educational supervisor and clinical supervisor.

We observed multi-disciplinary board rounds attended by medical staff, therapies staff and nursing staff, as well as a discharge co-ordinator. The board rounds were organised and detailed the patients' medical history, current treatment plan and any important information, such as; resuscitation status or further clinical reviews required. Discussions also prioritised patients who required a medical review, followed by those patients who could potentially be discharged.

Managers could access locums when they needed additional medical staff. Locum staff were given a full induction prior to before commencing duties.

### Records

**Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care. However, records were not always stored securely.**

Patient notes were comprehensive, and all staff could access them easily. The trust used a paper based multidisciplinary record system. Some electronic records were kept, such as diagnostic investigations.

We reviewed 20 sets of patient records and found they were clear, up-to-date and comprehensive and staff could access them easily. Clear pathway documents were used throughout the patient pathway. Risk assessments and associated care plans were completed in all records reviewed.

Staff completed and recorded intentional care rounding. Intentional care rounding is a structured process where staff performed regular checks with individual patients at set intervals. For example, we observed healthcare assistants visiting patients every hour during the day to check that call bells and drinks were within reach and they asked if the patient was comfortable or in any pain. We saw these were documented in the patients' records we reviewed.

Electronic records were stored securely when not in use. Electronic records were stored using passwords and access only given to authorised members of staff. However, paper records were not always stored securely. The paper notes were stored in lockable notes trolleys. Trolleys were cited by the central nurse's station however, we observed on multiple wards the trolleys were often left unlocked. This meant patient notes were not always secure. This was an issue highlighted at our last inspection.

### Medicines

**The service did not always use systems and processes to safely prescribe, administer, record and store medicines.**

The trust had implemented an electronic prescribed and medicines administration system (EPMA). This was used on most of the wards we visited. However, its use on the wards was varied with some people still using paper charts depending on where they had been admitted from or the medicines they were prescribed. Staff told us there was no formal system in place to indicate where patient's prescriptions were written and so there was a risk of medicines being missed. The wards relied on communication between staff to know who had medicines prescribed electronically, on paper or both. However, we saw no impact on patient care during the inspection.

# Medical care (including older people's care)

There was a system in place to ensure patients received medicines as prescribed. The EPMA system would flag those people due medicines and would ensure that an appropriate time frame between medicine doses was adhered to. Paper records were clinically screened and audited by a pharmacist at least once a week. Nurses also checked charts daily during administration rounds. During our inspection, we did not see any gaps in prescription charts. Monthly audits were undertaken to identify missed/omitted doses.

There were daily multidisciplinary team meetings on the medical wards to review and assess patient's treatment, including their medicines. Due to staffing levels a clinical pharmacist was not always available in these meetings but could be consulted with when required.

Each ward had access to a clinical pharmacist though staffing levels in the pharmacy department meant that a pharmacist would be working between multiple wards over a week and not always available in person each day.

Medicines advice and supply were available seven days a week. An on-call pharmacist was available outside of core working hours. Staff outside pharmacy were well informed of this and knew the routes to contact pharmacy at all times of the day.

Staff generally followed systems and processes when safely prescribing, administering, and recording medicines. We reviewed eight prescription charts and found medicines were generally prescribed in line with best practice and records of administration were consistently completed. Staff recorded patients' allergies and all records were legible, clearly dated and signed. However, on one ward 'when required' (PRN) medicines to control behaviour did not always have a reason for prescribing recorded. Staff were not always recording the reason why they had made the decision to administer a medicine.

Staff generally stored and managed medicines and prescribing documents in line with the provider's policy. On most wards we visited, medicines were stored safely in locked cupboards and refrigerators behind locked doors, or in medicines trolleys that were secured. However, there was no clear policy for monitoring ambient room temperature to ensure medicines were stored at the correct temperatures. We were told there was usually air conditioning available in these rooms to keep them cool. Medication fridge temperatures were monitored centrally by pharmacy who would alert the trust if there were concerns about a fridge temperature.

On two wards there were some unsecured medicines on the worktop and floor of the clinic room. We were told that non-nursing staff could access the room which meant medicines were not always only accessible to authorised staff.

Controlled drugs (CD) were generally stored correctly according to the Misuse of Drugs (Safe Custody) Regulations 1973. We saw that controlled drugs usage was recorded in appropriate secure records, checked and administered daily by two nurses. However, on one ward the open and expiry dates of bottles of medicines were not always recorded. We found two out of date controlled drug liquids in the CD cabinet that had not been identified and disposed of appropriately. Trust policies and procedures for date checking of medicines had not been followed by staff.

Staff followed current national practice to check patients had the correct medicines. There was a process to monitor and record medication administration on all wards. Staff ensured that the right patient had the right medications. All patients had their name on their wrist bands, these were checked before administration to ensure the right patient was getting the right medicine.

Staff provided counselling to patients and/or their carers to explain changes in medicines or when new medicines were started. We were told a clinical pharmacist and pharmacy technician were based in the discharge lounge and provided a final check of medicines and patient's understanding of new medicines before they went home. The pharmacy department was also making use of links with community pharmacy to ensure that people were supported after they had returned home with any new medicines.

There was a system in place for pharmacy to monitor and act on medicines safety alerts. The trust had a medicines safety officer (MSO) who was part of the pharmacy team. Any information was cascaded to each ward where appropriate for it to be acted upon. The MSO had recently worked on a project with a multidisciplinary team to improve the care of insulin dependent diabetic patients following a trend of errors around these medicines. The training and resources developed had helped to reduce the risk of harm to patients in this group.

The trust used an incident reporting system to record near misses and errors and learning from this was shared within the trust. Staff were able to tell us about the most recent shared learning from incidents, as well as what actions were put in place to reduce the chances of these happening again. Pharmacy staff had been actively working to train ward staff to reduce the number of medicine administration errors occurring.

### Incidents

**The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**

The service used an electronic reporting system which all grades of staff had access to. All staff we spoke with knew what incidents to report and how to report them.

There had been no never events from November 2020 to October 2021 in medical specialties at the trust. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From November 2020 to October 2021, there were 21 serious incidents reported in medical specialties at the trust. Twelve of the 21 serious incidents related to slips, trips and falls. Senior leaders told us the learning from falls incidents was integrated into the recently developed falls strategy and the team had developed a falls prevention and management workplan to reduce the incidence of falls.

Each incident had been reported and investigated in accordance with the trust's policy for incident management. Divisional leaders met twice each week at a serious incident review meeting to discuss incidents, plan their investigation and share any immediate actions and learnings. We reviewed serious incident investigations and found them to be sufficiently detailed to allow learning and sharing of learning across the division.

The trust had an openness and candour policy which staff could access through the services' intranet. The duty of candour is a regulatory duty that relates to openness and transparency. Staff we spoke with were aware of the importance of being open and honest with patients and families when something went wrong, and of the need to offer an appropriate remedy or support to put matters right and explain the effects of what had happened.

# Medical care (including older people's care)

Mortality and morbidity was a standing agenda item in the monthly specialty meetings. The divisional lead attended the mortality surveillance group which met monthly to look at deaths and identify if there was any learning to be shared. We reviewed the minutes from the September, October, and November 2021 meetings. The meetings were multidisciplinary, minuted and detailed how learning from the deaths was shared. The divisional leadership team (DLT) submitted a monthly mortality case learning report to the Divisional Board Meeting outlining a summary from the reviews completed including any learning identified.

Managers shared learning about incidents with their staff and across the trust. Lessons learned were disseminated through corporate and divisional forums. These included, but were not limited to; safety huddles, newsletters, clinical governance meetings, team meetings, and bespoke training on wards. The DLT shared learning from incidents through the monthly divisional leadership team newsletter.

Managers ensured that actions from patient safety alerts were implemented and monitored.

**Safety thermometer**

**The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.**

Although the safety thermometer had not been used since 2019, the information previously collected for the safety thermometer was included in the trust's integrated performance report (IPR). This data was also displayed on wards for staff and patients to see. The service displayed the number of falls, infection incidents and pressure ulcers.

Safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Wards displayed information in a way that was meaningful to patients and visitors. Performance on the safety thermometer was discussed as part of the clinical governance process.

The trust wide harm free care forum met monthly. The forum reviewed falls, pressure ulcers and infection prevention and control issues to monitor and drive improvement and reported to the clinical governance executive group.

## Is the service effective?

**Good** ↑

Our rating of effective improved. We rated it as good.

### Evidence-based care and treatment

**The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.**

# Medical care (including older people's care)

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Clinical guidelines were reviewed at the monthly governance meetings, where there was a log of what guidance required updating and approving. Policies and procedures reviewed were in date, and easily accessible to staff from the trust's intranet.

The service had a series of care pathways in place based on national guidelines. This included guidance for the assessment and treatment for conditions such as falls, sepsis and non-invasive ventilation (NIV).

The service had a structured audit programme to ensure practise was reviewed and audits were completed to ensure staff followed local and national guidance.

Staff protected the rights of patients subject to the Mental Health Act 1983 (MHA) and followed the Code of Practice. Nursing and medical staff had a good understanding of MHA and code of practice. Staff were able to explain how patients detained under the MHA were being treated for their mental health concern and if they required treatment for a physical illness, consent would have to be sought in line with current legislation.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. This ensured that appropriate referrals to specialist staff for example speech and language, occupational therapy, physiotherapy or the mental health team were actively managed.

### Nutrition and hydration

**Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.**

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. The service made dietary adjustments for patients for religious, cultural, personal choice or medical reasons when required. Patients on specialist diets had this highlighted on the board above their bed and care plans reflected individual patient's dietary needs.

Patients had jugs of water within easy reach on their bedside tables. They told us that these were topped up regularly and the choice and quality of the food was good.

Protected mealtimes were in place across the hospital wards. Protected mealtimes encouraged the hospital to stop all non-urgent clinical activity on wards during mealtimes. We observed healthcare workers providing support to patients with eating and drinking.

Staff fully and accurately completed patient's fluid and nutrition charts where needed. We saw completed fluid balance charts to monitor fluid input and output for patients receiving intravenous fluids.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. The trust used the malnutrition universal screening tool (MUST) as the validated screening tool. As well as identifying adults at risk of malnutrition, it also identified those patients who required dietetic input due to a medical condition or because of surgery. It was used to assess, and record patients' nutrition and hydration needs, and we saw that nurses had completed this in the records we reviewed.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it.

### Pain relief

**Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain**.

Staff assessed patient's pain using recognised tools and gave pain relief in line with individual needs and best practice. Nursing staff assessed patients' pain regularly, as part of their routine observations.

Patients received pain relief soon after requesting it. Patients told us they received pain relief quickly and staff responded positively to additional requests for pain relief. We observed staff carrying out medication rounds and asking patients for their level of pain, if their pain relief was effective and if they wanted to discuss their pain relief with medical staff.

Staff prescribed, administered and recorded pain relief accurately. From the eight prescription records we reviewed, we noted pain relief was prescribed, administered and recorded appropriately.

### Patient outcomes

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvement. The service had been accredited under relevant clinical accreditation schemes.**

Information about the outcomes of patients care and treatment was routinely collected and monitored. Ward managers displayed quality and safety information including results of the safety thermometer, complaints and friends and family test results to inform patients and visitors of their performance at the ward entrance.

The service maintained a dashboard which reported on items such as serious incidents, compliance with infection, prevention and control, complaints, and referral to treatment times. The dashboard tracked monthly performance against locally agreed thresholds and national targets, where available.

From June 2020 to May 2021, patients across medical specialities had a slightly lower than expected risk of readmission for elective admissions and a slightly higher than expected risk of readmission for non-elective admissions when compared to the England average.

The service participated in relevant national clinical audits. Examples included, but were not limited to, national audit of dementia, and national inpatient falls audit. Performance in national outcome audits were variable. However, appropriate action was taken to monitor and review the quality of the service and to effectively plan for the implementation of changes and improvements required. For example, we saw evidence of a falls prevention and management workplan, and local dementia action plan to improve patient outcomes.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The division showed evidence of a planned approach to clinical audit. A forward programme of audits for the current year was in place and progress against the plan was monitored.

Staff ensured they had ownership of things that had gone well and that needed to be improved. We saw the specialties discussed audit results as part of their local governance and where necessary had action plans to address any developments.

The endoscopy department was accredited by The Joint Advisory Group (JAG) for gastrointestinal endoscopy.

### Competent staff

**The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**

The service had processes in place to identify training needs and compliance, which ensured staff were confident and competent to undertake their roles.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. A competency framework was in place for both health care workers and trained nursing staff. A practice development nurse was in post to support staff to undertake training and oversee completion of training.

Managers gave all new staff a full induction tailored to their role before they started work, which included mandatory and role-specific training. Staff told us they received a comprehensive induction when they commenced work at the trust. This included a trust wide and local induction. The local induction included orientation to the area and support to complete local competencies.

The service provided development opportunities for staff at various grades, such as supporting nursing staff to move to the next level of seniority and the development of specialist roles. Nurses told us they were encouraged and supported to develop areas of interest and act as a source of advice for the team. Staff were also given the opportunity to undertake additional training courses that was relevant to their role and specialty. For example, nurses working on the stroke ward had their neuro-specific competencies assessed, such as, the ability to complete swallow assessments, and staff on the respiratory wards had completed training in tracheostomy care and non-invasive ventilation. Staff in cancer services received competency-based training to enable them to carry out their roles effectively.

Managers supported staff to develop through yearly, constructive appraisals of their work. As of 31 October 2021, 87% of staff across medicine had received an appraisal. This was an improvement since our last inspection. A number of actions had been taken to improve compliance, including business controls established through divisional and directorate performance meetings, and improvement plans in place across all teams.

### Multidisciplinary working

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

Observation of practice, review of records and discussion with staff confirmed that all necessary clinicians were involved in assessing, planning and delivering patient care and treatment. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Staff in all areas of the service told us they worked closely together to make sure patients received person-centred and effective care. Staff reported good relations and communications with other professionals and/or agencies.

# Medical care (including older people's care)

There was evidence of multidisciplinary working, for example, nurses working alongside specialist nurses, medical staff, healthcare assistants, pharmacy, and allied healthcare professionals. Notes we reviewed supported this.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Board rounds were completed daily and were attended by consultants, junior doctors, the ward manager, nurses and allied health professionals. Discussions included patient milestones, discharge journey, plan for patient, whether Mental Capacity Act (MCA) Deprivation of Liberty Safeguards (DOLS) were in place and whether the patient required a speciality review or escalation.

Meeting minutes confirmed regular multidisciplinary meetings were held and were well attended. These included morbidity and mortality meetings and joint multi-disciplinary speciality meetings.

Staff referred patients for mental health assessments when they showed signs of mental ill health and or depression. Staff we spoke with during our inspection were aware of the mental health liaison teams and provided examples of cases where they referred patients to the service.

Care pathways were multi-disciplinary, and staff of all disciplines developed and supported each other in the planning and delivering of patient care. Each professional group recorded their assessments in patient's medical notes, and it was therefore easy to access information about the outcome of the valuation and the ongoing care of the patients from each professional's perspective. It was clear which clinician had the overall responsibility of care.

Throughout our inspection, we observed good interactions between medical, nursing and support staff on all areas we visited. Staff we spoke with confirmed there was good multidisciplinary team working within the service and with external organisations.

### Seven-day services

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

Consultants reviewed patients regularly depending on the care pathway. All patients were seen by medical staff on a daily basis. Consultants on the acute assessment unit were available seven days a week and all new patients were seen on a daily basis.

Access to medical support was available seven days a week throughout the service. Consultant cover was provided seven days per week, with on-call arrangements out of hours. Palliative care and haematology (blood specialist) consultant advice was available out of hours, including weekends and bank holidays. Endoscopy and radiology services were also available out of hours.

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. There was access to therapy services seven days a week with on call arrangements out of hours.

The critical care outreach team and the hospital at night team provided a good level of cover and staff told us they were very responsive to requests for assistance.

There was a seven-day frailty service provided to the medical wards, this included a 'frailty phone' service to reduce hospital attendances. A GP and community team was also part of the service who could facilitate or support early discharges for frailty patients.

# Medical care (including older people's care)

Pharmacy services were available Monday to Friday 9am to 6.30pm, Saturday and Sunday 9am to 5pm, with out of hours on-call pharmacists available outside of these times. Diagnostic tests, for example, CT and x-rays were available 24 hours a day, seven days a week.

Chaplaincy support was available 24-hours a day, seven days a week.

### Health promotion

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

The service had relevant information promoting healthy lifestyles and support on the wards. Information was available on a range of subjects.

The trust used the 'End PJ paralysis' initiative which pointed to evidence that if patients stayed in bed in their pyjamas for longer than they need to, they would have a higher risk of infection, loss of mobility and ultimately stay in hospital for longer. Staff had displayed posters throughout the wards encouraging patients to get up and get dressed.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Patients had a medical history taken on admission to the ward. Medical history could include information such as smoking and recreational drug use.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

**Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.**

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 2005 and knew who to contact for advice. There was an up-to-date consent policy for staff to follow. Patient records we reviewed showed consent was obtained in accordance with the service policy. We observed consent being obtained for patients before their endoscopy procedure.

Staff made sure patients consented to treatment based on all the information available. Patients were given information about their proposed treatment both verbally and written, to enable them to make an informed decision about their procedure. Patients said staff fully explained their treatment and additional information could be provided if required.

Staff clearly recorded consent in the patients' records. Out of the 20 patient records we reviewed, staff had recorded patient consent where required.

Staff we spoke with could describe and knew how to access policy and get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. We saw evidence of the correct process documented in patient notes.

# Medical care (including older people's care)

## 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.**

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 engaging with patients in a positive and personalised way. Staff attitude was positive, and the atmosphere was warm and welcoming. Patients said staff treated them well and with kindness. We spoke with 13 patients during the inspection and they all had positive comments about the hospital and staff. Patients told us all staff were wonderful, caring and thoughtful.

Staff followed policy to keep patient care and treatment confidential. Staff closed curtains around patient bed spaces when delivering care to protect privacy and dignity. We observed staff knocking on doors, politely asking before opening curtains and waiting to be invited into rooms and cubicles.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff understood and appreciated the varying social and religious needs of their patients. They provided examples of accessing the chaplaincy service for patients who wanted spiritual assistance.

### 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. Staff understood the impact that a patient's care, treatment or condition had on their wellbeing and on their relatives, both emotionally and socially. Staff explained how they helped patients understand their condition and signposted them to organisations to help them manage their condition. Clinical nurse specialists were available for additional advice and support and provided ongoing emotional support to patients.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff were aware of the importance of maintaining patients' dignity and privacy, especially if they were distressed or confused. Throughout our inspection, we saw that distressed patients were spoken to kindly. Patients, who were confused, were given clear details of the time and place, and offered reassurance of safety.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. At staff handovers staff demonstrated great empathy and understanding for the patients and families, discussing plans in a sensitive and professional manner.

Chaplaincy support was available. Patients' spiritual needs were considered irrespective of any religious affiliation or belief. The chaplaincy service supported spiritual care across the services and ensured the delivery of spiritual, pastoral and religious care was adequate and appropriate.

### 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. Patients we spoke with told us staff communicated with them in a way, which they could understand, explaining their care, treatment and condition. All patients we spoke with told us staff fully involved them in their care.

We observed staff asking patients what they would like to be called and introduced themselves and their role. We observed staff involving patients during assessments and when taking observations on the ward.

Staff talked with patients in a way they could understand, using communication aids where necessary. We observed staff using language that patients understood and gave patients time to ask questions if they were unsure about anything. Staff interacting with confused patients showed genuine empathy, gave patients extra time and reassurance.

Staff recognised when patients needed additional support to help them understand and be involved in their care and treatment and enable them to access this. We saw, and staff told us how they could access language interpreters, sign language interpreters, specialist advice and advocates. There were special arrangements made for people living with dementia on medical wards.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients and their relatives provided feedback by completing patient surveys, and through the complaints and compliments procedure. We also saw thank you cards displayed in wards. Data provided by the service showed in October 2021, patients level of satisfaction ranged from 80-100% across all medical wards, with the average level of satisfaction of 92%.

Staff supported patients to make advanced decisions about their care. Staff told us patients and families about the importance of making advanced decisions so that they could make decisions about what happened to them.

Staff supported patients to make informed decisions about their care. Staff spoke openly with patients about the risks and benefits of procedures and treatment plans, so they could make informed decisions about their care. We noted where patients lacked capacity, family members had been involved in decision making and staff had a good understanding of the need to involve families and those close to the patient in their care.

## Is the service responsive?

**Good** ↑

Our rating of responsive improved. We rated it as good.

# Medical care (including older people's care)

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

**The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**

Managers planned and organised services, so they met the needs of the local population. The service understood the different requirements of the local people it served by ensuring that it actioned the needs of local people through the planning, design and delivery of services. Services were planned in a way which ensured flexibility and choice.

The service worked collaboratively with external agencies to improve services provided by the trust. This included working with the clinical commissioners, general practices and neighbouring NHS trusts to identify the needs for the local community and planning of clinical pathways to meet demands.

The frailty service aimed to identify patients with frailty as soon as possible, to improve outcomes, including reducing avoidable hospital admissions and supporting patients to be cared for in the community.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Staff were familiar with the importance of same sex accommodation. We saw evidence of single sex bays, toilets and shower facilities on all wards.

Facilities and premises were appropriate for the services being delivered. As a result of the COVID-19 pandemic, the service had reviewed the wards which enabled the service to continue to provide care for non COVID-19 patients.

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. The service worked well with local teams embedding a pathway to care and manage patients living with a mental health condition or a learning disability.

The service had systems to help care for patients in need of additional support or specialist intervention. Specialist nurses were available and assisted staff with the management of patients admitted to the hospital with various medical conditions.

## 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. They coordinated care with other services and providers.**

Patients were assessed on admission to identify any additional support or needs, and this was provided when required. For example, a skin integrity assessment identified any needs for pressure relieving equipment. We saw patients' needs were assessed and appropriate equipment used to ensure patient safety.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The service had systems in place which were able to identify patients requiring additional support. Any patients living with dementia or a learning disability were highlighted during the daily safety briefings so that the appropriate teams could be involved.

Wards were designed to meet the needs of patients living with dementia. The trust had a dedicated ward that supported patients living with dementia. The environment was dementia friendly and contained some adaptations to meet the needs of patients living with dementia or recovering from delirium.

We saw speech and language therapists were available on all wards and provided advice, support and equipment for people with problems with communication such as aphasia (or dysphasia), a condition which affects an individual's ability to use and understand language effectively. We observed therapists supported and involved patients appropriately with their therapy assessments on all wards.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff we spoke with knew how to meet the communication needs of patients with a disability and where to go for more assistance if necessary. Staff told us they would speak to specialist staff if they were unsure how to communicate with patients.

Managers made sure staff, patients and their loved ones and carers could get help from interpreters or signers when needed. Staff could access a translation service for patients whose first language was not English. All staff we spoke with knew how to access this service.

### Access and flow

**People could not always access the service when they needed it. Waiting times from referral to treatment were not always in line with national standards. However, recovery plans were in place to reduce waiting times. Arrangements to admit, treat and discharge patients were in line with the national average.**

Managers monitored waiting times however, patients could not always access services when needed and did not always receive treatment within agreed timeframes and national targets. As at September 2021, referral to treatments (RTT) times of patients treated within 18 weeks varied between 41.8% and 99%. Gastroenterology and cardiology were the poorest performers in terms of treating patients within 18 weeks.

Gastroenterology had seen a particularly large decline in performance when compared with pre-pandemic performance. In September 2019, 69.2% of gastroenterology patients were treated within 18 weeks compared to 41.8% in September 2021. Dermatology had also seen a large decline in performance when compared with pre-pandemic performance. In September 2019, 92.5% of dermatology patients were treated within 18 weeks compared to 77.4% in September 2021.

In the September 2021 data, there were six cardiology patients waiting more than 52 weeks for treatment. There were none in any other medical specialty.

The divisional leadership team told us there were recovery plans in place to reduce waiting times. A number of actions had been taken including, continued work to embed 'Patient Initiated Follow-ups' across eligible specialities within the division. This allowed clinicians to see when patients had a flare up, so they could see them within a hot clinic rather than generate clinic appointments that may incur significant waits. The trust had also increased the number of virtual appointments and all medical specialities had moved to a fully electronic triage system for GP referrals in e-referral.

In addition, the trust had implemented an Elective Care Restoration and Improvement (ECRI) programme, which included a number of projects designed to reduce the time patients were waiting for treatment and improve the trust's RTT position. The programme was clinically led, with senior operational management support, and wider project support from the better hospital team. Governance arrangements were in place, ensuring oversight from the operational management executive group, with reporting to the finance and activity committee through the senior leadership team to ensure the board was fully sighted on the programme progress and any risks.

# Medical care (including older people's care)

The programme had a continued focus on the restoration and improvement of services to ensure recovery of waiting times and actions to improve RTT performance following the COVID-19 pandemic. The programme also focused on ensuring patients were treated according to clinical need as per the National Clinical Prioritisation Programme, and National Planning Guidance.

The trust were also working with the wider Norfolk and Waveney system to ensure patients were treated in a timely way and to reduce inequality of access for patients across all specialities.

A divisional and speciality level recovery trajectory had been developed to inform the trust and integrated care system (ICS) planning submissions as per the national planning guidance, and elective and diagnostic elements were updated and published weekly. The medicine divisional general manager and deputy chief operating officer met weekly to discuss the recovery position for planned care and RTT to ensure escalation and action as required. Weekly operational updates across all divisions and specialities were provided to the chief executive leadership meeting (CELM), which highlighted areas of risk to delivery of the elective recovery plans and actions to mitigate these.

A harm review process was in place to identify any patients who had come to harm as a result of breaches in RTT. Data provided by the service following our inspection showed as of 17 December 2021, no patients had been harmed due to breaches in RTT for the division of medicine.

The trust performed in line with England averages in relation to national cancer targets. The trust had been continuously above the England and East of England averages for two-week cancer waits and treatment within 31 days.

The service had systems in place to improve access to timely treatment. Patients were generally admitted to the medical wards from the emergency department (ED), or from the acute medical unit (AMU). Staff had access to diagnostic services, such as computerised tomography (CT) scans and magnetic resonance imaging (MRI), seven days a week.

The endoscopy unit accommodated inpatients and outpatients. Out of hours arrangements were in place for procedures to be carried out by the on-call consultant.

Managers and staff worked to make sure patients did not stay longer than they needed to. The service worked with external services to ensure that patients were able to return to their homes as soon as possible. From July 2020 to June 2021 the average length of stay for medical elective patients was 6.2 days, which was similar to the England average of 6.3 days. For the same period, the average length of stay for medical non-elective patients at the trust was 5.0 days, which was lower than England average of 5.7 days. We saw evidence of patients ready for discharge being prioritised at the board round. Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Managers and staff worked to make sure that they started discharge planning as early as possible.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. The trust performed better than both the England average (69.5%) and the East of England average (63.5%) for delayed discharges in September 2021 (44.3%).

Staff tried to minimise movement of patients between wards at night. The service moved patients only when there was a clear medical reason or in their best interest. The COVID-19 pandemic had impacted on the movement of patients as patients had to be moved to the ward most appropriate for their care.

Managers monitored and took action to minimise missed appointments. Managers ensured patients who did not attend appointments were contacted.

# Medical care (including older people's care)

### Learning from complaints and concerns

**It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.**

The hospital had a clear process in place to ensure complaints were dealt with effectively.

Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke with, confirmed that they knew who to contact if they had a complaint or wanted to raise any concerns.

The service displayed information about how to raise a concern in patient areas. Leaflets informing patients how to make a complaint or how to contact the patient advice and liaison service (PALS) were available. PALS provided advice and support to patients who wished to raise a concern or complaint.

Staff understood the policy on complaints and knew how to handle them and tried to resolve any patient concerns immediately to prevent the concerns escalating to a formal written complaint. Staff understood the principles of duty of candour and could describe them.

Managers investigated complaints and identified themes. From December 2020 and November 2021, the trust received 80 complaints in relation to the medicine division. The information, themes and learning was used to drive improvements, innovation and further develop pathways and processes to ensure the patients experience was continually developed throughout the trust.

Managers shared feedback from complaints and compliments with staff and learning was used to improve the service. Complaints were discussed at governance meetings, team meetings and handovers, as well as trust board meetings to ensure staff understood shared learning from complaints to improve performance.

## Is the service well-led?

**Good** ↑

Our rating of well-led improved. We rated it as good.

### 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.**

There was an established leadership structure within the medical division. This included a divisional director, divisional general manager and a head of nursing. They were supported by clinical directors, matrons and ward managers. Staff we spoke with told us the management team were supportive and visible within the wards.

We met with the divisional leadership team (DLT) who spoke with pride about the work and care their staff delivered on a daily basis. The team demonstrated an awareness of the service's performance and the challenges they faced and had identified actions needed to address them.

# Medical care (including older people's care)

The leadership team were committed to nurturing and developing a more coordinated approach to enable quality improvement to be embedded across the service. Senior leaders were involved on a day to day basis, to support a safe and effective approach to clinical staffing and patient flow.

They worked collaboratively to make improvements in the effectiveness and responsiveness of care. They supported staff to take ownership of the issues, reflect and consider their practice and be open to new ways of working. For example, following a number of serious harm cases resulting in patients falling, the trust had developed a new falls strategy. In addition, all wards were asked to undertake a deep dive of falls in their area to identify themes and trends, and actions taken to improve the incidence of falls.

Senior leaders had a thorough understanding of the improvements that were needed to strengthen the quality of their service. They understood the challenges to quality and sustainability the medical care service faced and had pro-active ongoing action plans in place to address them.

At local level matrons oversaw multiple wards and assisted ward managers. We observed matrons were visible on the wards. Ward managers said they were supported by the matrons and senior leads.

Ward managers were organised and demonstrated strong and supportive leadership. They were knowledgeable about the ward's performance against the trust priorities and the areas for improvement.

The local leads were supportive of staff development, for example, we spoke to a ward manager who informed us their matron was encouraging and helpful and the senior management were accessible.

### Vision and Strategy

**The service had a vision for what it wanted to achieve and a strategy to turn it into action. Leaders and staff understood and knew how to apply them and monitor progress.**

The divisional leadership team (DLT) described how a workplan had recently been launched which set out the vision and strategy for the medicine division. Their vision and strategy underpinned the corporate vision and strategy and was to be the best rural district general hospital for patient and staff experience. Their mission was to work with patients, staff, and partners to improve the health and clinical outcomes of their local community. The corporate strategy included six strategic objectives, each with an executive director lead. The overarching strategic objectives had a range of underpinning key performance indicators, and plans were in place to publish quarterly reports for patients, partners and staff to monitor progress.

The trust vision and strategic objectives were underpinned by the core values of act well, care well, listen well. Staff we spoke with knew and understood the trust's values and could talk about how they demonstrated these values in their work.

### Culture

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

All staff we met were welcoming, friendly and helpful. It was evident that staff were passionate about the services they provided. Staff were committed to providing the best possible care for patients.

# Medical care (including older people's care)

We observed good working relationships across the service, and it was evident that staff morale was good in areas we visited. Staff spoke with pride about their role and told us they felt respected and valued by their managers and senior management team. They described the COVID-19 pandemic as being a major challenge and the culture had been based on working together to respond to the demand.

Staff at all levels told us there was good team working throughout the service. Staff worked together to provide the best possible care for patients. During our inspection, we observed positive and respectful interactions, which were focused on meeting patients' needs and providing safe care and treatment.

The service had mechanisms in place for providing all staff at every level with the development they required, including high-quality appraisal and career development conversations. Staff told us they found appraisals useful.

Staff were encouraged to report incidents and felt confident in doing so. The culture encouraged openness and honesty. Processes and procedures were in place to meet the duty of candour. Where incidents had caused harm, the duty of candour was applied in accordance with the regulation.

All staff we spoke with were aware of the whistleblowing policy and many staff told us they would escalate concerns or challenge colleagues if patient safety was compromised.

### Governance

**Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service**.

The governance framework in medical services ensured staff responsibilities were clear and quality and performance risks were understood and managed. Senior staff understood their roles in relation to governance and their level of accountability with regard to providing a safe service to patients and their families.

The divisional leadership team told us there had been a complete overhaul of the governance structure since our last inspection. New roles had been established, including a risk and governance lead, a quality and safety lead and risk and governance champions.

At divisional level, regular quality assurance meetings, risk and governance meetings, and divisional incident sign off meetings were held. These fed into the divisional board meetings and divisional performance review meetings. Discussions evidenced the divisional board had oversight of mandatory training, incidents, complaints, finance, workforce, risks, quality, mortality, audit, complaint and feedback from staff and patients.

In addition, bi-monthly clinical governance meetings were held at specialty level which showed evidence of discussions of patient safety, mortality and morbidity, risks, safety alerts, audits, performance, training compliance and ongoing operational challenges to the quality of the services.

There was an effective governance structure and risk management framework to support the delivery of high-quality care. All incidents reported through the incident reporting system were reviewed daily. This was to ensure the service was safe and identify any immediate actions required to address safety concerns. Potential serious incidents were reviewed in more depth at weekly meetings and were escalated when necessary.

Staff were able to describe the governance structure across all levels of the service and believed communication, on the whole was good. There were systems to review the National Institute for Health and Care Excellence (NICE) guidelines and other nationally recognised guidance.

All levels of governance and management functioned effectively and interacted with each other appropriately. The committee structure was used to monitor performance and provide assurance of safe practice. There were a range of systems and processes of accountability which supported the delivery of safe and high-quality services, including regular governance and team meetings. Staff at all levels were clear about their roles and understood what they were accountable for and to whom.

There was a systematic programme of internal audit used to monitor compliance with policies such as hand hygiene and infection control. Audits were completed monthly, quarterly or annually depending on the audit schedule. Results were shared at relevant meetings, such as governance and team meetings.

Managers maintained various dashboards which reported on activity, workforce and compliance with a wide range of safety and quality indicators covering incidents, audit, infection prevention and control, and patient experience. The dashboard tracked monthly performance against locally agreed thresholds and national targets, where available. A traffic light system was used to flag performance against agreed thresholds. A 'red flag' indicated areas that required action to ensure safety and quality was maintained. Exceptions (red flags) were reviewed at governance meetings and action was taken to address performance issues when indicated.

### 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.**

There were assurance systems in place, and performance issues were escalated appropriately through clear structures and processes. There were processes to manage current and future performance, which were regularly reviewed at specialty and divisional meetings. There was a systematic programme of clinical and internal audit to monitor quality, and systems were in place to identify where action should be taken.

The service had robust arrangements in place for identifying, recording and managing risks. The medical division had a risk register which included a description of each risk, an assessment of the likelihood of the risk materialising, its possible impact and the lead person responsible for review and monitoring. We observed the risk register was monitored within the governance framework and regularly reviewed.

Key quality performance indicators were measured and reported monthly to the trust board. They covered a wide range of quality indicators, including number of pressure ulcers and falls, infection control indicators, incidents, complaints, referral to treatment time performance, and friends and family test results.

All the medical wards had a display board visible to visitors and staff, with details of their performance in relation to some of the ward quality indicators and also their planned and actual staffing levels.

The division had a planned approach to clinical audit. An audit plan for the division was in place and progress was monitored.

There were regular staff meetings to share learning from incidents and complaints. Where specific actions were required, they were fed back at daily handovers and safety briefings.

Staff were aware of the duty of candour requirements which identified the importance of sharing information with patients and families when an incident had occurred which involved them. Duty of candour principles had been applied to particular incidents we reviewed.

The trust had a policy and plans in place for emergencies and other unexpected or expected events, such as adverse weather, flu outbreak or a disruption to business continuity.

### Information Management

**The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**

The service had clear performance measures and key performance indicators (KPIs), which were effectively monitored. This included a dashboard and clinical area KPIs. The dashboard parameters were presented in a format to enable it to be used to challenge and drive forward changes to practice. The parameters had been set in agreement with local and national thresholds, which allowed the service to benchmark themselves.

Audit data was reviewed at clinical speciality level meetings. This meant there was a service awareness of performance. The clinical and divisional directors had oversight of all specialties within their division and escalated to the trust board appropriately. This enabled decision makers to have the relevant, up to date information to inform decisions being made about the service.

Information technology systems were used to monitor and improve patient care. There were arrangements in place which ensured data such as serious incidents and never events were submitted to external providers as required.

During our inspection, we saw the arrangements in place to ensure confidentiality of patient records were not always robust. Computer terminals were locked when not in use, to prevent unauthorised staff from accessing confidential information. However, we found on multiple wards notes trolleys where patient records were kept were unlocked.

### Engagement

**Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

The service collaborated with partner organisations to help improve services for patients. There were positive and collaborative relationships with external partners and stakeholders to build a shared understanding of challenges and the needs of the local population, and delivery of services to meet those needs. The service worked collaboratively with service users, neighbouring NHS trusts, and commissioners.

The three acute hospitals in the integrated care system had launched joint services to improve services for patients and provide better access to care. A single clinical team ran the Norfolk and Waveney urology service across the three hospital sites. This brought together skilled teams across the services to share best practice, provide the same access and quality of care and provide opportunities for patients to help improve services and create new pathways.

People's views and experiences were gathered and acted on to shape and improve the services and culture. Service user feedback was sought to inform changes and improvements to service provision. The three acute trusts hosted a virtual carers conference in carer's week in June 2021 which was co-produced with carers. The event included carers and led to additional funding to improve involvement of carers at admission (emergency and planned) and discharge and to improve awareness of carers through staff training. This was led by carers.

The patient experience team had attended meetings and focus groups with Healthwatch, a disability charity and a local university to engage with them as part of their patient experience strategy to understand what they would like to see at the trust.

Information about the complaints procedure and patient advice and liaison service was available in clinical areas. Feedback was also gathered through social media forums.

Annual staff surveys were undertaken to help identify areas for improvement.

Regular emails, team meetings, notices in staff areas, and safety briefings ensured staff were informed about important updates.

Our discussions with staff indicated they were positively engaged and confident to raise concerns. In many instances they said they were asked for their ideas and listened to.

### 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 and participation in research.**

There was a focus on continuous improvement and quality. Leaders were responsive to any concerns raised and performance issues and sought to learn from them and improve services.

Staff of all disciplines were committed to improving service provision and patient experience. Staff were encouraged to provide examples of improvements and changes made to processes based on patient feedback, incidents and staff suggestion. Staff were alert to new initiatives and ways of working.

The Same Day Emergency Care (SDEC) unit won a government award in late 2020, specifically the Best Use of a Solution aware and runners-up in the Efficiency in the Property Portfolio and the Special Recognition categories. The SDEC was launched to help reduce pressure on the trust's emergency department by streamlining the initial assessment and admission of patients, enabling them to get the treatment they needed quickly.

Over 40% of all outpatient activity continued to be delivered through virtual means; telephone or video (Attend Anywhere). This was above the NHS Long Term Plan target of 30% and the current H2 guidance of 25%. H2 guidance sets out the national priorities for the NHS, including reducing waiting times.

The division continued to work to embed 'Patient Initiated Follow-ups' across eligible specialities within the division. This prevented patients from being admitted to hospital, and also allowed clinicians to see when patients flared up, so they could see them within a hot clinic rather than generate clinic appointments that may incur significant waits.

# Medical care (including older people's care)

The division had successfully embedded referral triaging across the majority of specialties within medicine. This resulted in patients being identified as potentially requiring a more urgent appointment than requested and earlier booking of diagnostic tests before their consultation. The established advice and guidance models provided speciality specific clinical assistance to primary care colleagues to either recommend referral to the speciality or to provide a recommended treatment plan to continue to care for the patient using primary care.

The trust implemented a model of virtual ward during the COVID-19 pandemic, allowing patients to be discharged from hospital at the earliest opportunity. Based on this success and in working with partners across the Integrated Care System (ICS), the trust had detailed deliverable plans to implement virtual ward within medicine, ensuring a greater proportion of patients discharged earlier from hospital with telemedicine.

Since the previous inspection, the frailty services within the division had been successful following recruitment drives. This had enabled a number of innovative schemes, including:

- Frailty in-reach to the acute medical areas and to the Emergency Department.
- Frailty phone advice for primary care and the ambulance service – the phone was held seven days a week by a Consultant. This had prevented avoidable attendances to hospital and therefore onward admission.
- The recruitment of a dedicated Frailty Consultant Nurse to the team.
- The recruitment of trained Cognitive Impairment Assessors to the frailty team who undertook Abbreviated Mental Tests on patients and recording compliance.

In conjunction with the corporate team, and in direct response to the COVID-19 pandemic and the restrictions on visiting to inpatient wards, the trust mobilised a number of family liaison officers to wards. They had a meaningful and profound impact to releasing ward staff to concentrate on patient care and to ensure relatives and next of kin could be contacted on a daily basis, improving communications in and out of the ward.

Smart phones and tablets were introduced on the medical wards, in order to facilitate video calls between inpatients and their relatives. Ward-based staff assisted the patients with these calls where assistance was needed.

The dedicated Coronary Care Unit (CCU) had been relocated and was now situated within Cardiology, for giving patients with heart disease and heart-related illnesses the best possible care. A robust training package had also been implemented, including coronary skill passports, to ensure all staff were empowered to provide the greatest level of care for their patients. An “in-reach” service was also provided for cardiology patients to support them as they prepare for discharge.

There was active participation in research throughout the medicine division.

# Urgent and emergency services

Good ↑

## Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good.

### Mandatory training

**The service provided mandatory training in key skills including the highest level of life support training to all staff and made sure everyone completed it.**

Nursing and medical staff now received and kept up to date with their mandatory training. Records showed staff achieved above the service compliance rate of 80% for all mandatory training except for venous thromboembolism (VTE) and tissue viability. Leaders had plans in place to provide the additional training and improve performance in these areas.

The mandatory training was comprehensive and met the needs of patients and staff. Staff accessed a range of training online learning or face-to-face. Training included but was not limited to dementia, mental capacity, life support and responding to deteriorating patients.

Managers monitored mandatory training and alerted staff when they needed to update their training. Leaders had access to staff training records and could liaise with the clinical educators in order to ensure staff compliance with mandatory training was being monitored. This meant leaders were aware of staff compliance and could manage any poor compliance to ensure staff had the appropriate skills and competencies to meet patient needs.

### Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**

Nursing and medical staff received training specific for their role on how to recognise and report abuse. Paediatric nursing staff achieved 100% compliance with safeguarding children training at level 1, 2 and 3. Paediatric Medical staff achieved 69% with level 1, 71% level 2 and 37% for level 3 which were below the services 80% compliance standard.

Nursing staff in the adult emergency department (ED) achieved 99% compliance with safeguarding adults training at level one and two, and 75% compliance with level three which was slightly below the service compliance standard. Medical staff achieved 88% with level 1 and level 2 safeguarding adults.

Leaders ensured safeguarding training had been delivered to improve compliance rates within the ED and ensured staff had the required understanding to recognise and respond to disclosures of abuse.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The service had systems and processes to identify frequent and repeat attenders, flagging patients on the services IT system to show staff where patients may need additional support or have ongoing safeguarding concerns. This meant staff could quickly identify patients at risk and take appropriate action to safeguard them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with knew how to report safeguarding concerns, report them on the IT system, make paper-based referrals where necessary and the contact details for the safeguarding team. This meant staff could report safeguarding concerns without any delays to ensure appropriate support was put in place for patients and relatives.

Staff followed safe procedures for children visiting the ward. The children's ED had a separate entrance monitored by CCTV which required swipe card access.

### 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. The ED was visibly clean in all areas. Throughout our inspection we noted domestic staff completing cleaning activities and using "I am clean stickers" to demonstrate equipment was clean and safe to use. This reduced the risk of infection to patients and staff.

Cleaning records were up-to-date and demonstrated all areas were cleaned regularly. Domestic staff completed cleaning in line with cleaning schedules, we reviewed the signed dated schedules which demonstrated these had been completed. Where deep cleans were necessary a separate cleaning team would come to the department to complete these. However, cleaning records in relation to children's toys were not always completed in the children's ED. This was often due to capacity issues and time constraints during periods of increased patient demand.

Staff followed infection control principles including the use of personal protective equipment (PPE). Hand washing facilities, alcohol gel and hand conditioner were readily available throughout the ED. The service had dedicated areas for staff to remove and apply PPE and clear signage was in place to remind staff, patients and visitors of the importance of infection control.

Staff followed, 'bare below the elbow' guidance, and wore PPE such as gloves and aprons while delivering care in line with service policy. The service implemented PPE stations at every entrance to the ED for staff and patients or their carers to access face masks and other PPE essentials. This meant staff were promoting a safe environment for patients and other staff. Staff hand hygiene audits from November 2021, showed staff routinely achieved 100% compliance.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff routinely cleaned patient trolleys and equipment between use and clear signage reminded staff, patients and carers of restricted access to high risk areas, for example areas where staff cared for infectious patients. This reduced the risk of cross infection from entering areas where a patient who may present an infection risk may be being cared for.

### Environment and equipment

**The design, maintenance and use of facilities, premises and equipment kept people safe, although some checks were not always carried out. Staff were trained to use them. Staff managed clinical waste well.**

Patients could reach call bells and staff responded quickly when called. Patients had access to call bells, and we observed staff responded to these quickly.

The design of the environment followed national guidance. The service had made improvements to the physical environment in order to manage increased demand and in response to the COVID-19 pandemic. The service had

increased space for ambulance handovers and used additional space within the outpatient department to meet the needs of patients with minor injuries. This had significantly improved social distancing and workspace for staff. The service had plans to develop the ED footprint to meet the needs of the local health care economy, which it had shared with internal and external stakeholders.

Staff did raise concerns regarding the children's ED and its ability to cope with increased patient numbers due to the COVID-19 pandemic. Leaders were aware of this issue; surge plans were in place and the emergency and urgent care service development plan reflected the changing needs.

Data provided by the service following our inspection showed staff carried out daily and weekly safety checks of specialist equipment. Staff achieved 97% compliance with daily checks and 100% compliance with weekly checks in September 2021. Staff compliance with daily and weekly checks fluctuated in October and November 2021, electronic alerts were sent to managers to inform them of any noncompliance and to ensure actions was taken to carry out checks.

The service had suitable facilities to meet the needs of patients' families. At the time of our inspection, ED staff restricted the environment to allow only patients and their direct carers to enter. No relatives, unless they were the patient's main carers, were allowed within the department due to the COVID-19 pandemic. We observed reception staff greeting patients and sensitively advising them relatives were not allowed and asking if the patient had any additional care needs to enable support to be provided.

The service had enough suitable equipment to help them to safely care for patients. During our inspection we noted staff had access to a wide range of appropriate equipment to enable them to treat and care for patients. Equipment was stored appropriately, and corridors were not crowded. There were systems in place to ensure the regular maintenance of equipment took place. The service's clinical engineering department serviced and repaired equipment. We found consumables within their expiry date and specialist equipment had been reviewed by the maintenance team at appropriate intervals.

Staff disposed of clinical waste safely. Staff ensured that clinical and domestic waste bins were segregated appropriately. Sharps bins we checked were signed, dated and stored appropriately.

### 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.**

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The service used the early warning score system (NEWS2) for adults and paediatric early warning scores (PEWS) for children. An early warning score is a guide used by medical services to quickly determine the degree of illness of a patient. It is based on the vital signs of respiratory rate, oxygen saturation, temperature, blood pressure, pulse and heart rate.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff used the Australian Triage process when completing initial patient assessments. Staff used the electronic patient record to record the patients NEWS and PEWS score. This enabled nursing and medical staff to identify their most poorly patients from a single screen and allocate resources accordingly. The ED coordinator always monitored the electronic screen, this enabled them to recognise any changes in the patient's condition and escalate this to the appropriate staff. We reviewed the records of eight patients and found the records to be up to date and risk managed appropriately.

Staff knew about and dealt with any specific risk issues. This included the management of sepsis, neutropenic sepsis, stroke, falls and patient pressure care. Staff ensured patients with frailty or pressure care needs were transferred from a trolley onto an appropriate pressure relieving mattress within four hours of arrival within the ED.

The ambulance crews called the ED in advance to alert staff to cases of sepsis, suspected stroke or gynaecology patients. The Hospital Ambulance Liaison Officer (HALO) would assist in this process, liaising with the ED ambulance coordinator ensuring patients were greeted at the hospital and taken to the most appropriate area for treatment. The service had clear escalation processes to manage any patients at risk of deterioration and to provide continuity of care for patients who may need to remain on ambulances should patient demand exceed capacity within the ED and lead to patients waiting on ambulances for extended periods.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff within the ED had access to mental health liaison staff 24 hours a day, seven days a week. The staff told us external mental health resources were limited. The service had conducted reviews where patients with mental health needs had remained in the department for extended periods to ensure their rights and choices had been upheld and to develop strategies to reduce waiting times for services.

Staff shared key information to keep patients safe when handing over their care to others. As some of the patient records were electronic, this enabled a wide range of appropriate professional staff to review and update patient records.

Shift changes and handovers included all necessary key information to keep patients safe. Staff held regular safety huddles and handovers at the beginning and end of each shift where they discussed patient needs, identified any specific risks or additional resources required. The ED team held nurse handover four times a day, supported by a nurse safety huddle twice a day. Staff held an additional safety huddle with the emergency physician in charge (EPIC) and nurse in charge every two hours and medical staff carried out handovers twice a day.

Data supplied by the trust showed 100% of paediatric nursing staff had completed life support training to level 2 and 59% to level 3. Additional training was planned to improve compliance rates in 2022. Consultant medical staff achieved 100% compliance with adult life support training.

## Staffing

### 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, and gave bank and agency staff a full induction.**

The service had enough nursing and support staff to keep patients safe. At the time of our inspection the nurse staffing levels were appropriate to the needs of the patients. The ED used a blend of nursing staff, health care staff, advanced nurse practitioners, nurse practitioners and paramedics to provide care and treatment to patients.

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. Leaders ensured planned staffing levels met the needs of patients. Staff rotas were planned and considered annual leave and any staff absences. Leaders had used a recognised staffing tool to assess staffing levels.

The department manager could adjust staffing levels daily according to the needs of patients. The nurse in charge worked closely with the matron and coordinators to ensure they had appropriate staffing levels and could escalate any concerns to the site team for support if there were shortfalls. In cases where patients needed additional support, for example patients with mental health needs, or complex cases, staff could escalate this through the site team to request additional staff.

The service had reducing vacancy rates for nursing staff. Recruitment had been successful, and leaders told us the ED had no vacancies at the time of our inspection. Data supplied by the service following our inspection showed the required nursing establishment as 72.47 full time equivalents (FTE). The services actual establishment was 73.89 FTE, which was 1.42 FTE above the establishment.

The service had low turnover rates. Turnover rates fluctuated between 6.56% in January 2021, and 8.45% in November 2021. Leaders told us this was often due to natural progression between roles or staff taking up other opportunities.

The service had reducing sickness rates. Sickness rates peaked in August 2021, at 11.10%, this reduced to 9.05% in September and 7.19% in October 2021. The service monitored sickness rates and had a range of staff interventions and wellbeing programmes to support attendance.

The service had reducing rates of bank and agency nurses between January 2021 and June 2021. There had been a gradual monthly increase in the use of bank or agency staff from July 2021 where it was 12.97%, to November 2021, 16.75%. Managers did try to limit their use of bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service.

### Medical staffing

**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. There was an increased turnover and vacancy rate with ongoing recruitment. Managers regularly reviewed staffing levels and skill mix, and gave locum staff a full induction.**

The service had enough medical staff to keep patients safe. The medical staff matched the planned number on duty and were dedicated to ensuring that cover was provided, often going over their hours to provide cover. At our last inspection in September 2020, the ED leadership team had submitted a business case to approve a permanent increase in medical staffing. At the time of our recent inspection the service was again recruiting substantive medical staff due to staff leaving the service and the rotation of junior doctors.

The service had an increased turnover and vacancy rate for medical staff. Between January 2021, and September 2021, the staff turnover rate remained consistent month on month. The number of staff leaving in November 2021 increased and the service was trying to recruit to these positions and locums had been recruited to provide cover. Managers made sure locums had a full induction to the service before they started work.

Leaders told us a longer-term solution was required as medical staff were feeling the pressure of increased patient numbers, 213 patients on the day of inspection, close to record high number for the service. Staff told us patient numbers like these were becoming the norm. Leaders explained that sustainability of workload was very challenging and although they provided 16 hours minimum presence for consultants in department, additional recruitment was required to sustain medical cover longer term.

The service had reducing sickness rates. Sickness rates peaked in August 2021, at 9.92%, this reduced to 4.32% in September and 3.36% in October 2021. The service monitored sickness rates and had a range of staff interventions and wellbeing programmes to support attendance.

In July 2021, the proportion of consultant staff reported to be working at the service was considerably lower than the England average. The proportions of middle career staff were considerably higher than the England average. Leaders recognised the need to invest in more ST3 level doctors, tier three (these Doctors should have the equivalent experience of emergency medicine to be able to be left in charge of the department at night with consultant non-resident on call) but were struggling for time and resources to achieve this due to the current demands on consultants within the ED.

The service provided consultant cover 8am to 10.30pm seven days per week and always had a consultant on call during evenings and weekends. After 10.30pm the ED team accessed the emergency physician in charge (EPIC) by an on-call rota. None of the consultants had any sub-specialty training in paediatrics. A consultant paediatrician was on site at the service until 8pm on Mondays to Fridays and from 9am to 3pm on Saturdays and Sundays, and on-call outside of these hours.

### 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 used a blend of paper based and electronic record systems. We reviewed eight patient records and found these to be comprehensive, clear, and up to date. The electronic system meant the name of the medical staff or nurse reviewing the patient was clear, the time that the patient was reviewed was clearly documented, and all notes were dated.

Staff used the electronic record to flag patients who may have additional needs, for example allergies, learning disability, safeguarding concern or a frequent or returning patient.

When patients transferred to a new team, there were no delays in staff accessing their records. As some of the patient records were electronic, this enabled a wide range of appropriate professional staff to review and update patient records.

Records were stored securely. Staff stored patient records securely and locked computer screens when not in use. The nurse in charge would check patient records as part of their two hourly safety checks to ensure patients were being seen on time, in the right area and having the correct care and treatment.

### Medicines

**The service used systems and processes to safely prescribe, administer, record and store medicines. However, antibiotics were not always recorded when prescribed on admission.**

Staff followed systems and processes to prescribe and administer medicines safely. The service was in the process of introducing an electronic prescribing and medicines administration system (EPMA). However, this was not yet available within urgent and emergency care. There was a paper-based system to prescribe and record the administration of medicines. Patients notes were held alongside their medicine's administration records.

# Urgent and emergency services

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. We reviewed the medicine records for four people in the ED. Medicines records included information on allergies. Medicines records showed patients were prescribed and administered medicines in line with the prescriber's intentions.

Staff completed medicines records accurately and kept them up to date. There was a system in place to ensure people received medicines including pain relief in a timely manner and this was reviewed regularly. A treatment plan would be started on entry to the service and then reviewed within an appropriate time frame by a senior clinician to ensure it met the patient's needs.

Staff stored and managed all medicines and prescribing documents safely. Medicines were stored appropriately so they would remain safe and effective for use. Temperatures were monitored regularly, and staff were aware of what to do if the temperature should go outside of the recommended ranges. Access to medicines storage areas and prescribing documents were restricted to authorised staff only. The service made use of a dual system of ID card and biometric data to access medicine storage areas. This could be audited if needed.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Sometimes when antibiotics were prescribed on admission there was no record of the reason for this. This does not follow best practice for antimicrobial stewardship to ensure antibiotics are being used appropriately.

Staff learned from safety alerts and incidents to improve practice. The service used an incident reporting system to record near misses and errors. Learning from this was shared within the service and staff were able to tell us about the most recent shared learning from incidents, as well as what actions were put in place to reduce the chances of these happening again. There was a system in place from pharmacy to monitor and act on medicines safety alerts. This information was cascaded to ED staff where appropriate.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. When a medicine was administered to manage agitation or aggression rapid tranquilisation (RT), a policy was in place to enable medicines to be appropriately prescribed and monitored. Staff we spoke with understood the requirements within the policy. Staff were aware of the need for increased physical health monitoring following use of RT and how this would be recorded.

## Is the service effective?

**Good** 

Our rating of effective improved. We rated it as good.

### Evidence-based care and treatment

**The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.**

# Urgent and emergency services

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Leaders had implemented a new staff role within the emergency department to specifically have oversight of policies and procedures. Staff had access to a wide range of up to date policies, procedures and guidance available on the service intranet which were version controlled. This enabled staff access to up to date guidance for the treatment and care of patients in the emergency setting.

Staff routinely referred to the psychological and emotional needs of patients and carers. Staff discussed patient needs at key points in their care and escalated any concerns regarding their care to the appropriate specialism.

### Pain relief

**Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief 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 in the children's emergency department (ED) administering pain relief and following the services medication policy.

Patients received pain relief soon after it was identified they needed it, or they requested it. We reviewed eight patient care records and where appropriate, staff had given pain relief in a timely manner, administered and recorded pain relief accurately.

### 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. The service leads told us that local audit outcome reports for Royal College of Emergency Medicine (RCEM 2019/20) audits had been created and presented within the respective speciality. Action plans were in place to respond to RCEM 2019/20 audits - Cognitive Impairment, Care of Children, (Mental Health Issues) and Mental Health Assessment recommendations required development and co-ordination within the local audit plan for ED.

Additional audits included Emergency Medicine, Severe sepsis and septic shock (care in Emergency Departments), Primary Care Streaming Service Evaluation, and the monthly audit of Non-Medical Practitioner Workforce Clinical Documentation. All of these were in progress and due for reporting in 2022.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment. Information from audits was displayed within the ED. Managers shared and made sure staff understood information from the audits and used governance and staff meetings to discuss areas of achievement or where improvements were required.

Improvement was checked and monitored. The service had a dedicated local audit plan for the ED services, including time scales and who was responsible for delivering the audit outcomes including how these would be shared.

The service carried out staff understanding and compliance with the Mental Capacity Act (MCA) 2005. Data supplied by the trust following our inspection showed in November 2021, 12 audit responses were received and analysed. These showed staff achieved 90% compliance or above in seven of the ten areas covered including but not limited to understanding how to access policies, where to document MCA outcomes and what constituted mental capacity.

# Urgent and emergency services

The service had a lower than expected risk of re-attendance than the England average. Reattendance within seven days of previous attendance had been below or fluctuating close to the East of England average and continuously below the England average for the last two years.

## Competent staff

**The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Leaders deployed staff to roles within the ED based on their competencies, skills and training. Clinical educators worked alongside the ED leadership team to support staff and ensure they had the right level of training and competencies for their role. This meant patients received care from staff who knew how to meet their needs.

Managers gave all new staff a full induction tailored to their role before they started work. Leaders ensured bank and agency staff received a full induction before starting their shifts in the ED. New staff entering the ED were assigned competency workbooks by clinical educators. This was to ensure staff competencies could be monitored over time to ensure they met the required professional standards and provided patients with appropriate care and support.

Managers supported staff to develop through yearly, constructive appraisals of their work. Leaders ensured staff received regular appraisals and the service now met the required internal standards for appraisals completion for nursing and medical staff. This meant staff achieved the right level of skills and competencies to enable them to fulfil their roles within the ED.

The clinical educators supported the learning and development needs of staff. The service employed two clinical educators that worked along staff to provide them with a blend of hands on supervision and guidance as well as access to online learning resources and teaching sessions. The service now met the required internal standards for mandatory training completion and the clinical educators worked with leaders to identify staff requiring additional support and guidance to achieve the necessary level of competency or training.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge and ensured staff received any specialist training for their role. Leaders identified any staff who required additional training and worked with the clinical educators to provide this. This provided additional experience and career opportunities for the wider staff team. For example, a member of staff who wanted to achieve higher levels of life support training in relation to children.

## Seven-day services

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

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week. The service recognised accessing mental health resources within the region was challenging. Leaders reviewed cases where patients with mental health needs had experienced significant delays in transfer to other mental health services in order to improve services for patients and reduce waiting times.

## Health Promotion

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

The service had relevant information promoting healthy lifestyles and support within the ED. The ED provided additional information on the management of health for patients who attended. Leaflets to guide patients and carers on the care of minor injuries were readily available.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff could refer patients to other services, for example diabetes support, alcohol and substance misuse, or frailty services.

### Consent, Mental Capacity Act and Deprivation of Liberty safeguards

**Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.**

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff we spoke with understood the need to support patients who lacked capacity and how to apply the MCA in order to provide appropriate care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed staff seeking consent from patients before offering care or treatment based on all the information available.

Nursing and medical staff now received and kept up-to-date with their MCA training. Data provided by the trust showed nursing staff achieved 99% compliance and medical staff 71%, which was just below the trusts target of 80% compliance.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Staff within the children's ED understood how to apply the competencies and guidelines in their day to day role.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff followed service risk assessments when managing patients who required additional support with their mental health needs. The service had conducted reviews where patients with mental health needs had remained in the department for extended periods to ensure their rights and choices had been upheld.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. Leaders carried out audits to review staff understanding of the MCA and how to apply this in their practice.

## Is the service caring?

**Insufficient evidence to rate** 

### Compassionate care

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

# Urgent and emergency services

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 treating patients with kindness and respect. Staff used privacy screens, curtains and knocked on closed doors to promote people's privacy and dignity. The staff always promoted a culture of kindness towards patients and each other and we observed positive interactions between patients and staff.

Patients said staff treated them well and with kindness. We spoke to a child who told us the staff had been kind and explained what was going to happen to them. We observed another member of staff speaking gently to an elderly patient and taking additional time to explain what was happening to them and providing reassurance.

### Understanding and involvement of patients and those close to them

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

Staff supported patients to make advanced decisions about their care. We observed staff ensuring that a patient with a do not attempt cardiopulmonary resuscitation (DNACPR) in place was treated with dignity and ensured they were in the right place to receive their care, despite the heavy patient demands in the department affecting the space available.

Staff provided feedback to a patient who had a long-standing health condition. The patient was discussing possible outcomes and asking questions regarding their care and treatment options. The staff were understanding of the patient's needs, offered a range of choices and encouraged the patient to make decisions about their care and treatment plan.

## Is the service responsive?

**Requires Improvement** 

Our rating of responsive stayed the same. We rated it as requires improvement.

### Service delivery to meet the needs of local people

**The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**

Managers planned and organised services, so they met the needs of the local population. Leaders worked with external stakeholders to responded to increased patient demand and meet the needs of the wider health care economy. Leaders were engaged with community health services, primary care services and other NHS organisations to adapt ED services. For examples, implementing general practitioner (GP) services within the ED to stream patients more quickly and safely and avoid hospital admissions while reducing patient waiting times.

Facilities and premises were appropriate for the services being delivered. The service had made improvements to the physical environment in order to manage increased demand and in response to the COVID-19 pandemic. The service had increased space for ambulance handovers and used additional space within the outpatient department to meet the needs of patients with minor injuries. This had significantly improved social distancing and workspace for staff. The service had plans to develop the ED footprint to meet the needs of the local health care economy, which it had shared with internal and external stakeholders.

# Urgent and emergency services

The service had systems to help care for patients in need of additional support or specialist intervention. The service had a rapid response and frailty team. The team provided urgent assessment of frail older patients coming into the ED. The service ensured patients received appropriate care, including avoiding admission where possible and provided 'wrap around' community support by liaising with other external health services.

### Access and flow

**People could not access the service when they needed it, waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.**

Managers monitored waiting times and made sure patients could access emergency services and received treatment. However, some patients were waiting long periods for decisions regarding their care and treatment, and decision to admit or discharge. At the time of our inspection bed occupancy on the medicine and surgery wards, (the main receiving wards when patients were transferred from the ED) was at 100%, reducing the ability to move patients' away from the ED into the ward areas.

The service ensured all patients who were waiting had actions in place including prompt review and nursing checks. Unfortunately factors such as high bed capacity, discharges, waiting for additional clinical review, or mental health referral were key factors affecting patients waiting times.

At the time of our inspection patient attendances were above pre-pandemic levels (October 2021 had 7,000 attendances compared to 5,500 attendances in February 2020 and 6,050 attendances in October 2019).

The Department of Health and Social Care's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED. The 95% target had been met only once (in June 2020, 5,899 attendances) since November 2019. NHS Digital - A&E quality indicators (October 2019 to September 2021) show that in the latest 12 months the service had been almost continuously worse than the East of England average and the England average. The service saw performance decline from 89.3% in March 2021 to 62.3% in October 2021.

Data supplied by NHS Digital - A&E quality indicators (October 2019 to September 2021) showed the percentage of patients waiting over four hours from the decision to admit to admission had been worse than the East of England average and the England average since May 2021. In October 2021 40.4% of patients waited over 4 hours compared to the England average of 30.7% and the East of England average of 24.9%. The service performed well since March 2020, for the median time to treatment and was consistently lower than the 60-minute target and the England average.

Between October 2019 to September 2021, the median total time for patients in the ED fluctuated close to the England average. The median time at the service for September 2021 was 185 minutes, compared to an England average of 186 minutes. The total time in the ED had been almost continuously below the England average but increased to similar to the England average in September 2021. Data from NHS Digital - A&E quality indicators (October 2019 to September 2021).

The number of patients leaving the service before being seen for treatments was low. Between Oct 2019 to Sept 2021, the percentage of patients who left before being seen was continuously lower than the England average and lower than the East of England average for all months apart from Dec 2020. In Sept 2021, 2% of patients left before being seen compared to the England average of 5.9%. Data from NHS Digital - A&E quality indicators (Oct 2019 to Sept 2021).

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Comparison to England or East of England averages was not possible for number of patients waiting over 12 hours from the decision to admit to admission. During the second wave of the COVID-19 pandemic the number of patients waiting over 12 hours from the decision to admit to admission increased steeply in Nov and Dec 2020 (Dec: 32 patients). The number of patients waiting over 12 hours increased to 58 from nine in Aug 2021. In Oct 2021, 25 patients waited over 12 hours. Data from NHS Digital - A&E quality indicators (Oct 2019 to Sept 2021).

In December 2020, the service carried out a thematic review of patients who waited over 12 hours within the ED. In September 2021, the service received information from NHS England and Improvement, advising they did not have to submit every 12-hour breach (physical or mental) as a serious incident unless significant harm was identified as a result of the breach. At that point the service ceased declaring 12-hour breaches as serious incidents and began to review each breach submitted on an incident-by-incident basis, escalating incidents of concern to the Serious Incident Review Panel (SIRP) and completed 72-hour reports following discussion at SIRP.

Data supplied by NHS Digital - A&E quality indicators (October 2019 to September 2021) showed a steady increase in median time to initial assessment (emergency ambulance cases only since March 2021 (10 mins). In September 2021, the median time to initial assessment was 27 minutes. There was a steady increase in the percentage of ambulance journeys with turnaround times over 30 minutes from February 2021.

There was a large increase in the number of ambulance journeys with turnaround times over 60 minutes from May 2021 onwards, which coincided with much higher total numbers of journeys. The service had implemented processes to try and improve these times and ensure any delays were risk assessed and patients received appropriate care while waiting.

## Is the service well-led?

**Good** ↑

Our rating of well-led improved. We rated it as good.

### 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 emergency department (ED) had a clear leadership structure, with defined roles and responsibilities. Leaders understood the priorities and risks within the ED, shared risk and performance data with the staff team and were visible within the department. This meant staff managed risk effectively and minimised patient harm while promoting patient flow through the ED.

The ED was led by the matron, clinical director and service manager. The matron led the day-to-day actives with the support of the nurse in charge and coordinators. The consultant in charge had day-to-day clinical and managerial oversight of the medical team.

Leaders supported staff to develop their skills and knowledge. Clinical educators worked alongside leaders to offer a range of development and training opportunities. Compliance with mandatory training and competencies had improved. Staff were clear on their roles and responsibilities in relation to professional standards and providing patient care.

### Vision and Strategy

**The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**

The service had an emergency and urgent work plan (2021-2022) and strategies to improve services within the ED. Leaders had implemented change based on the work plan, which had led to improvements in the physical environment, management of patient risk and performance. The physical environment for adult patients had improved due to increased space, staff compliance with mandatory training and competencies had improved and staff managed risk effectively and minimised patient harm.

The leadership team worked with internal and external stakeholders to plan for the needs of the wider health economy. Staff gave examples of integrating general practitioner services within the ED, improving links with community-based care, increasing the size of the ED to increase capacity and implement streaming services to redirect patient flow to other care providers where appropriate. The ED work plan focussed on sustainability and was aligned to local plans within the health care economy.

### Culture

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

The service had a positive culture, promoted staff and patient engagement and opportunities to improve services from feedback. The service had a freedom to speak up guardian and routine staff engagement to enable staff to share concerns or positive feedback. Staff felt highly valued and respected the local leadership. Positive messages were displayed within the department to encourage kindness and teamwork amongst the staff team.

The teams knew the demands on the department and recognised the increase in patient numbers. The additional demand had impacted on staff welfare and staff expressed concerns that they could not sustain the level of activity longer term. Leaders had implemented additional welfare and emotional support for the staff team in response to these concerns.

Staff we spoke with knew who the freedom to speak up guardians were. Staff felt confident to raise concerns to the coordinator, nurse in charge or the matron. We observed nursing and medical staff openly challenge each other and discuss individual patients to ensure the patients received the right care at the right time.

### Governance

**Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service**.

# Urgent and emergency services

The service had established governance systems. ED governance meetings occurred monthly, with attendees from multidisciplinary staff across the service and reported to the divisional team. Governance meetings were comprehensive and covered a wide range of clinical and operational performance areas, for example risk management, mortality and morbidity, complaints, incidents and other key performance issues. Leaders provided feedback to staff in various formats to share learning from incidents and complaints and raise awareness of risks. The governance framework aimed to progress quality and standards, improve patient safety and provide positive outcomes for patients and their families.

### 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.**

Leaders and teams used systems to manage performance effectively. Leaders maintained an up to date risk register related to the department, this was reviewed monthly by the governance team and risk was escalated from ward to board dynamically as they emerged. ED risks included patient flow through the department, response to the COVID-19 pandemic, waiting times and ED capacity. Staff used feedback from governance to improve the patient experience, increase staff knowledge and skills and improve the patient experience.

Leaders used established escalation processes to manage crowding and demand within the ED. Processes for managing ambulance handovers were embedded, and the service had surge plans to deal with times of increased demand. Staff did raise concerns regarding the children's ED and its ability to cope with increased patient numbers due to the COVID-19 pandemic. Leaders were aware of this issue; surge plans were in place and the emergency and urgent care service development plan reflected the changing needs.

### Information Management

**The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.**

The service collected reliable data and analysed it. Leaders now shared risk and performance data with the ED staff team. Information was easily accessible and displayed within the department, shared through safety huddles, team meetings, internal dashboard, and at governance meetings. Staff used this data to manage patient flow, reduce the impact of patient waiting times and improve the patient experience.

### Electronic systems were secure, password protected and easily accessible by authorised staff.

### Engagement

**Leaders and staff actively and openly engaged with staff the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

Leaders actively promoted engagement with internal and external stakeholders. Staff meetings and safety huddles were an everyday occurrence and feedback from staff was encouraged to improve the patient experience and support staff in their day-to-day activities. Leaders used IT based systems to hold meetings due to the impact of the COVID-19 pandemic, and these were now embedded practice to maintain communication, manage performance and governance oversight.

# Urgent and emergency services

Leaders worked with external stakeholders to respond to increased patient demand and meet the needs of the wider health care economy. Leaders were engaged with community health services, primary care services and other NHS organisations to adapt ED services. For example, implementing general practitioner (GP) services within the ED to stream patients more quickly and safely and avoid hospital admissions while reducing patient waiting times.

### 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.**

The ED leadership team was engaged in the national innovation 'NHS 111 First' and implemented direct bookable services to try and reduce the increased attendances to ED. The project group was supported by system partners from the local clinical commissioning group (CCG), NHS ambulance service and other community health care providers. The project group started in July 2020 and the service went live with a 24-hour service in July 2021.

The ED leaders were developing an Advanced Care Practitioner (ACP) programme. The service recruited an ACP lead in July 2021 and was in the process of recruiting five new trainee ACPs who would be completing their training to provide future stability and consistency to the workforce.

The ED staff team introduced support packs for relatives of patients who were receiving end of life care in the department. These included a keepsake pot to store the patient's valuable items (for example a wedding ring), car parking voucher, a bereavement pack and information regarding emotional support available.

Working with an external charity and maternity services, the ED staff team introduced support packs for women who presented to the department with a suspected miscarriage. These provided patients with information on emotional support available to them as well as products to support their dignity while in the department.

The ED leadership team implemented a rapid staff induction booklet developed at the start of the first wave of COVID-19. This gave staff a quick orientation before them starting work in the ED and gave them an overview of the department. The booklet was designed to be used alongside the services induction processes and to provide specific information for the role.

A mental health education working group had been developed and staff meet regularly to discuss mental health education and service improvements / delivery in the ED. These meetings were held every two months and were attended by ED educators, an ED consultant, an ED paediatric lead and the mental health team from both the service and external mental health service providers.

# Critical care

Good

## Is the service safe?

Good

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

### Mandatory training

**The service provided mandatory training in key skills to all staff and made sure everyone completed it.** However, medical staff compliance was not always in line with trust targets.

Nursing staff received and kept up to date with their mandatory training. Mandatory training was provided in person or by electronic learning sessions. Topics included clinical and non-clinical subjects such as basic life support, fire safety, manual handling, and governance. Compliance across nursing staff training was above the trust target of 80%, with most topics being over 95%. The only exception was moving and handling with 69% compliance.

Medical staff received mandatory training; however, their compliance was not in line with the trust targets for seven out of 16 topics. Trust data showed compliance was between 53% (infection prevention and control level 2) and 73% (fire safety). Actions were in place to improve training compliance.

The mandatory training was comprehensive and met the needs of patients and staff. We were told clinical staff completed additional topics to non-clinical staff and in some areas to an enhanced level. Staff were required to complete training in line with their role, although we were told that capacity issues within the service and numbers able to attend training due to social distancing had impacted on staff ability to access training in a timely manner.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers were able to allocate staff to training and had access to compliance records. When necessary, managers could facilitate staff to attend sessions and allocate on clinical rotas when training was planned to take place.

### Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.** However, medical staff compliance was not always in line with trust targets.

Medical and nursing staff received training specific for their role on how to recognise and report abuse. Safeguarding training was completed to the level most appropriate to the role. For example, staff who were in patient facing roles were trained to safeguarding adults' level 2. Those staff who had contact with children completed safeguarding children level 3 training. All other staff completed safeguarding children level 2 training.

Compliance for safeguarding adults' level 1 and 2 and safeguarding children level 2 was 100% for nursing staff. Safeguarding children level 3 was completed by 99% of nursing staff.

Compliance for safeguarding adults' level 1 and 2 was 87% in medical staff and children’s safeguarding level 2 was 80% and level 3, 73%, below the trust target of 80%.

Although the majority of patients within the department were sedated, staff were knowledgeable about safeguarding and knew how to escalate any concerns and who to contact for advice. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were able to give examples of where they had escalated concerns and referred patients to the local authority. We also saw that all safeguarding concerns were recorded through incident reporting.

Staff followed safe procedures for children visiting the ward. The service had restricted visiting in response to the COVID-19 outbreak, although children were not routinely allowed into the clinical area. Before anyone visited, staff spent time with them explaining what they would see when they entered the unit. We saw that staff had information leaflets which detailed common critical care treatments and equipment.

### 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.**

Clinical areas were clean and had suitable furnishings which were visibly clean and well-maintained. There was adequate handwashing facilities and sufficient space between beds to enable staff to complete their jobs without difficulty. Disposable curtains were used, and these were changed regularly and between any infectious patients. We saw dates were clearly recorded of when this happened.

Staff completed damp dusting and used appropriate cleaning materials routinely. Nursing staff were responsible for keeping clinical equipment and areas clean and labelled equipment as clean and ready for use.

The service performed well for cleanliness. Local infection control and prevention, environmental audits were completed. We saw compliance was 100% for hand hygiene audits for September to November 2021.

Cleaning records were up-to-date and demonstrated all areas were cleaned regularly. There was a dedicated domestic team who completed regular cleaning of the department in line with infection risks. Cleaning schedules were in place for regular cleaning and staff were able to access a team to complete deep cleaning between patients. Staff reported they considered domestic staff as part of the team and had regular communication with them.

There were two side rooms available for patients to be isolated in the event of a communicable infection. During inspection we saw that one room was occupied by a patient with a known infectious illness. The other was empty in preparation for any patient with COVID-19. We saw that one patient with a communicable illness was being cared for on the main unit, however, steps were taken to prevent cross infection. There was an empty bed each side and additional screens in use. This had been discussed and agreed with the infection prevention and control team as the need for a dedicated side room for a COVID-19 admission was deemed to be of a higher risk.

Staff followed infection control principles including the use of personal protective equipment (PPE). Since the outbreak of COVID-19, staff had adopted the use of enhanced PPE. Staff were observed to wear masks, aprons, and gloves for all patient interactions. Staff washed their hands regularly and were seen sanitising hands on entering clinical areas. We were given examples of how PPE was adapted in line with guidance for higher risk patients and how the team limited access or cross over between patients.

# Critical care

During the COVID-19 first wave, the unit had nursed patients in the main ward area due to increased numbers. Staff explained the additional steps taken to ensure staff and patient safety. There were dedicated areas, used for donning and doffing (the putting on and removal of protective equipment), and routes through the department were clearly defined. Staff were able to close intersecting doors which separated beds to form two separate units, one for those with infections and one for those patients without. All staff knew what PPE and pathway was required according to risks and teams did not cross cover.

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

Relatives were not permitted into the unit unless there was a specific need and prior agreement from the nurse in charge. This had changed during the pandemic, and staff were seen explaining visiting and any additional protection that was required. All visitors were required to wear a mask and gown when attending the unit.

### 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.**

Critical care was located on the first floor of the main hospital building, and easily accessible for patients who may be transferred from acute clinical areas such as the emergency department and theatres.

The service had been temporarily relocated due to structural concerns with the roof earlier in 2021. The roof had been reviewed by structural engineers as part of a rolling hospital wide maintenance programme, and rapid actions were required and taken to ensure patient and staff safety. An internal critical incident was declared for urgent repair works to be carried out. The service had relocated to the theatre's recovery for the two week period to ensure safety and the installation of emergency failsafes. The environment was suitable to needs and well maintained.

The service was accessible through restricted access doors with a call bell for visitors to use. All visitors were required to be let in by a member of staff which prevented tailgating.

The design of the environment followed national guidance. There was sufficient space between bed spaces and designated hand washing sinks available for staff to use. There was sufficient space for patients to be attended by multiple clinicians if necessary. There was limited storage areas, and due to the increased number of specialist equipment being used, some areas were slightly cluttered. However, this did not impact on staffs' ability to work.

All equipment was identified as having been checked by the estates/maintenance team in line with trust requirements.

Staff carried out daily safety checks of specialist equipment and equipment such as suction and oxygen in each bed space was checked at the start of each duty. This was in addition to daily checks of equipment such as resuscitation trolleys and medicine fridges. Records showed equipment was checked, and staff reported if there were any issues. The unit also had access to emergency equipment such as difficult intubation trolleys which were set up in preparation for any incident, which prevented any delays in accessing equipment required. Audits showed over 93% compliance for emergency equipment checks from September to December 2021.

Each bed space always had several pieces of equipment available, for example, syringe drivers and intravenous infusion pumps. There was additional equipment in an easily accessible storeroom, and staff told us there was adequate equipment for the needs of the service.

Patients could reach call bells and staff responded quickly when called. Those patients that were not sedated were able to call for assistance using a call bell although we saw that these were seldom used.

The service had suitable facilities to meet the needs of patients' families. There was a dedicated patients relatives' room which enabled relative to stay overnight if necessary. We were told that the services could use camp beds borrowed from other clinical areas. The trust also had a cabin which was used by families to enable them to be close to relatives who were dying.

Staff disposed of clinical waste safely. Clinical waste was stored in secure areas and collected regular to prevent a build-up of refuse.

### 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. Nursing staff used an electronic record to record key information, such as clinical observations, sedation scores, ventilation mode, medications administered, intake and output and any care plans for the day. These were accessible at the patient's bed space to ensure that key information was accessible throughout the patients' admission.

Staff completed risk assessments for each patient on admission/arrival, using recognised tools, and reviewed these regularly, including after any incident. Risk assessments were reviewed and repeated daily or in line with the guidance. For example, some assessments required weekly reviews.

All risk assessments, and next of kin contact details and care plans were accessible electronically at any computer within the unit. There was also a backup paper system which could be used in the event of system failure. We saw that staff were informed of any planned outages in advance enabling preparation for alternative recording of information.

Staff knew about and dealt with any specific risk issues. There were clear processes in place to ensure all key information was shared with the nurse in charge and doctor on duty. We saw that any concerns were escalated in a timely manner. Staff completed regular huddles to ensure the team knew what was going on.

The ward handovers included a discussion with the named nurse to ensure all information was discussed. We were told that during COVID-19, the team had utilised telephone conferencing to ensure clinicians outside the unit could be involved with discussions on care and treatment along with the nurse caring for the patient on the unit. The nurse was able to dial into a conference call from the bed space to ensure inclusion in discussions.

Staff were able to describe the use of sepsis screening and how they applied the principles to ensure patients were treated for any suspected infections in a timely manner. Staff reported there were robust processes for admitting and treating patients with confirmed or suspected sepsis.

We saw venous thromboembolic (VTE) assessments were completed for all patients on admission, and prophylaxis medication considered as part of daily ward rounds.

The service had 24-hour access to mental health liaison and specialist mental health support. Although this service was infrequently used due to the type of patients cared for, staff knew how to access mental health support if necessary. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Patient cared for as high dependency patients were able to be referred for additional mental health assessments or care if necessary.

Staff shared key information to keep patients safe when handing over their care to others. We saw there were robust processes in place to ensure an adequate handover between care providers. Shift changes and handovers included all necessary key information to keep patients safe. Within critical care, staff provided an oversight handover at shift changes, and then allocated staff to particular patients depending on the staffs' competencies, or to ensure continuity of care. This enabled staff to be familiar with all patients currently within the department and the ongoing risks or concerns. The oncoming staff member would then receive a detailed handover of care from the staff member who was finishing their duty.

When patients were transferred between clinical areas, staff utilised a transfer information checklist which contained all relevant information.

Patients who required additional support outside the critical care unit could be referred to the critical care outreach team (CCOT) who attended patients offering support and advise. The service provided two nurses where possible, who would assess patients and provide a plan of care. We were given examples of where the CCOT attended patients in other clinical areas and advised on treatments such as oxygen therapy to help improve patients' conditions. Referred patients were monitored and reviewed regularly until their condition improved or the patient was transferred to critical care. Patients discharged from critical care were also followed up by CCOT until such a time as they were stable and requiring no further interventions.

The CCOT team provided a 24-hour service with an increased number of staff (two) available in evenings and at weekends when there were less staff available across the trust. This ensured that they were always available to patients at risk.

### Nurse staffing

**The service had 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 and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.**

The service had enough nursing and support staff to keep patients safe. Patient to staff ratio for care provision was in line with national guidance. The number of nurses and healthcare assistants matched the planned numbers. During inspection we saw there was adequate staffing to manage the department and, in the event, where there was reduced activity in the unit, staff were relocated to support other clinical areas. Staff told us this happened regularly.

The critical care outreach team was managed separately to the critical care unit which meant that, the outreach team were protected from working clinically within the department. We were told the outreach team rarely worked within the department and managers protected their time due to the need for continued specialist support across the rest of the hospital. Trust data confirmed this with no occurrences of staff working in critical care for the six months preceding inspection. Outreach staffing consisted of seven whole time equivalent (WTE) staff which enabled a 24-hour service daily, although this did not enable two staff to be on duty, which had been necessary due to increased pressures on the service since COVID-19.

# Critical care

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. Off duty was planned to ensure adequate staffing for the number of patients within the department. There were 60.57 whole time equivalent (WTE) staff who worked flexibly to meet demands.

All shifts had an allocated coordinator which was protected, as far as possible from taking a patient. Staff reported that the coordinator was supplementary to the numbers which enabled them to attend the ward round and gain oversight of the unit's activity, and that they rarely took responsibility for a patient when coordinating.

The ward manager could adjust staffing levels daily according to the needs of patients and we were given examples of staffing pressures and fluctuations due to capacity demands during COVID-19. The unit had used staff from other clinical areas, such as theatres and agency staff during the COVID-19 first wave outbreak. Although substantive staff had returned to their substantive posts, agency staff could be used if there was a need.

The service had an increasing vacancy rate in response to recent changes within the team. Staff told us they were actively recruiting. The service did not recruit newly qualified staff.

The service had a higher turnover rate than expected at 12.11%, however, the reasons for leaving were captured and reported as being in response to relocating to be closer to families, promotion, and new posts at other trusts.

The service had low sickness rates. We were told that for the last six months the sickness reporting for nursing staff was lower than the trust target and data showed that the current sickness rate was 3.54% for nursing staff.

The service had low rates of bank and agency nurses, although could increase use if there were additional demands on the service. Trust data showed that any requests for agency staff were filled with over 82% fill rate for September to November 2021. Data showed that in September, 3.75% of the nursing workforce was agency staff, 3.99% in October and 5.75% in November 2021.

We were told staffing could be challenging especially when the unit was divided into two clinical areas with COVID-19 positive patients. Managers used bank and agency staff familiar with the service where possible. We were given examples of how staff had been offered regular work during the COVID-19 first wave to provide some stability to the workforce. We were also told all bank and agency staff had a full induction and understood the service.

### Medical staffing

**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. Although this was maintained by consultants working additional hours.**

Medical staffing consisted of seven consultants against an establishment of eight, although we saw that staff on duty matched planned numbers, and there was a good skill mix of medical staff on each shift. However, this was managed by consultants working additional hours. There were seven consultants with one planned to leave in the next few months. Consultants told us they worked additional hours to ensure that there was continued medical cover within the unit and to ensure patient safety. The team had a recruitment process in place and were in the process of advertising posts.

# Critical care

There were adequate numbers of junior and trainee doctors to enable a doctor working in the unit 24 hours per day. There was a mix of junior doctors and registrar who covered the unit. Consultant cover was 8am to 10pm, Monday to Friday with an on-call consultant overnight. The service always had a consultant on call during evenings and weekends. Weekend cover consisted of an on-call consultant who completed a minimum of two ward rounds per day.

Junior medical staff reported that they could access senior support easily and they always had access to either a registrar or consultant. They also reported their education and training programmes continued to take place.

The service had a low vacancy and turnover rate for medical staff. The seventh consultant had only just informed the team of their impending departure and in response the team had met to discuss what actions were needed to ensure cover for the unit and safety.

Sickness rates for medical staff were low, medical sickness was reported as 2.48% in October 2021.

The service had low rates of bank and locum staff. Managers could access locums when they needed additional medical staff. Doctors' numbers were supplemented by locum staff who worked regularly on the unit. Managers made sure locums had a full induction to the service before they started work.

Junior medical staff reported that although the workload had increased and there had been staff shortages due to COVID-19, staffing levels were adequate to cover the workload. This was achieved by arranging cover for absences in a way that did not significantly increase the workload of any one staff member. They did not feel the workload for this service had increased any more so than that of some other acute services during the COVID-19 pandemic.

### 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. The service used an electronic patient record system which captured all activity, treatment and details of meetings and ward rounds. Staff were able to access the patients record at any computer within the unit.

The electronic record system facilitated the capturing of all patients' clinical observations, medicines, and nutritional and hydration records. We saw that ward rounds were clearly recorded, and detailed discussions and treatment plans agreed. We reviewed eight patients records and saw they were clear and described plans of care and ongoing treatments. Risk assessments were completed and reviewed regularly in line with guidance and escalated where necessary. For example, we saw referrals to specialist support staff such as dietitians clearly recorded in notes.

The service completed a records audit monthly and shared compliance internally. Service leads addressed any issues with documentation at the time of identification to ensure the action was timely. We were told the team had started attending the documentation forum, in December 2021 and now contributed to the good practice audit.

All patients had ongoing physiotherapy notes which outlined treatments provided and plans for care. For example, we saw patients who were awake but not yet recovered enough to be discharged were assisted / planned to mobilise.

When patients transferred to a new team, there were no delays in staff accessing their records. On discharge, patients' records were transferred with the patient to ensure there was access to all relevant information.

# Critical care

Preadmission (to critical care) written notes were held centrally on the unit to ensure access. We saw these contained details of any assessments and interventions by the critical care outreach team (CCOT). CCOT records were detailed and included a patient clinical assessment and plans of care or treatment. Written notes were legible with details of each clinician and contact numbers.

Records were not stored in locked trolleys; however, they were held in the nurse's office which was not accessible to non-authorised persons.

### Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. There was clear guidance and standard operating procedures for the administration of medicines.

Medicines were reviewed daily by the clinical team and all patients underwent a sedation pause to ensure sedation was at the most appropriate level. There was not a dedicated critical care pharmacist however, staff reported there was a pharmacist who attended the ward round at least once per week and advised on medication management. The lack of dedicated pharmacist was on the teams' risk register.

Staff completed medicines records accurately and kept them up to date. Prescription charts were detailed with patient weight and demographics. These were checked before any administration and signed to confirm when medicines had been given. Trust data showed compliance with medicines audits was 100%.

Staff stored and managed all medicines and prescribing documents safely. All medicines were secured in line with guidance, including controlled medicines (those requiring additional secure measures due to legislation).

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Prescription charts were reviewed as part of the transfer process and any current medicines were outlined between teams. The pharmacist would complete medicines reconciliation when attending the unit to ensure the patient was prescribed the correct medication in line with any treatments before admission to the unit.

Staff learned from safety alerts and incidents to improve practice. Any alerts were shared by the pharmacy team to each clinical area. This process enabled staff to discuss anything pertinent to their service and taken any actions. Staff told us they discussed any alerts at handovers.

### Incidents

**The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**

Staff knew what incidents to report and how to report them. Staff used an electronic reporting tool which automatically escalated incidents to managers and in the event of a serious incident, to the leadership team. This enabled timely review of all incidents and necessary actions to be implemented.

Staff raised concerns and reported incidents and near misses in line with trust policy. We saw staff routinely reported incidents. Records showed staff reported incidents relating to clinical and non-clinical issues or concerns such as

staffing, delayed discharges or admissions and any near misses. Records showed 70 incidents had been reported from June to November 2021. The themes included reporting of tissue damage (26 pressure ulcers due to equipment or positioning), ten clinical incidents such as lines being accidentally removed or humification not being in place, eight incidents relating to equipment, five injuries such as staff trips, four late discharges (after 10pm), and multiple one-off incidents such as error in records or COVID- 19 testing not being completed before admission.

The service had no never events in critical care. Service leads were able to describe the process for learning from incidents and told us investigations were completed by a nominated person, who independently reviewed the incident and any actions taken. This enabled an impartial assessment of an incident.

Managers shared learning with their staff about never events and serious incidents that happened elsewhere. Staff were aware of never events that had occurred within surgical services, and actions that had been taken to address them.

Staff understood the duty of candour (DoC). They were open and transparent and gave patients and families a full explanation if and when things went wrong. We saw that details of DoC were recorded in incident records to enable auditing and oversight of actions taken.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us they received feedback from incidents they reported as individual reporters and as a team. We saw that incidents were discussed at team and governance meetings.

Staff met to discuss the feedback and look at improvements to patient care. We were told how all serious incident investigations were investigated fully and shared across the whole team before the investigation was signed off as being completed. This ensured incidents were challenged across all staff groups.

The team completed structured judgement reviews of all deaths to identify if there were any areas for learning. We saw examples of the reviews which showed that patients demographics were reviewed, along with details of their illnesses, communications with families, prognosis, discussion regarding end-of-life care and the outcome of the review.

## Is the service effective?

**Good** 

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

### Evidence-based care and treatment

**The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.**

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We reviewed policies and saw these were up to date and reflected current and up to date practice. There was a process for ensuring policies were reviewed as part of the services governance meetings.

# Critical care

Leads monitored performance through regular audits internally and externally. Locally, staff participated in the trust wide audit programme which looked at staff adherence to infection control practices, record keeping and monitoring of risk.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Patients admitted to the service who had a mental health act section were cared for by the critical care nursing team but, had additional support from mental health teams, as necessary. Staff were able to access mental health colleagues or refer patients if there were concerns about their wellbeing. Staff recorded clearly in patients notes when there were concerns and what actions had been taken. For example, we saw a patient with an attempted overdose was referred for mental health support.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers. Handovers included all aspects of the patients' care including any support the family or patient needed.

### Nutrition and hydration

**Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.**

Staff made sure patients had support with nutrition and hydration to meet their needs. Patients who were sedated were reviewed by the dietitian and commenced on nasogastric feeding (by a tube into the stomach through the nose). Those patients who were able to eat, were supported by staff to access food that was suitable to their dietary needs and preferences. For example, some patients required a soft diet due to issues with swallowing following intubation.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Records we reviewed confirmed this.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Patients were assessed using a national tool and action taken appropriately. For those patients at risk, additional support was accessed. Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it.

### Pain relief

**Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patient's pain was managed and staff clearly recorded pain scores when patients were awake. Those patients who were sedated routinely received pain relief medicines.

Patients received pain relief soon after it was identified they needed it, or they requested it. We saw prescriptions identified timely medicines administration. Staff prescribed, administered, and recorded pain relief accurately.

### 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 had been accredited under relevant clinical accreditation schemes.**

# Critical care

The service participated in relevant national clinical audits. The team completed the Intensive Care National Audit and Research Centre (ICNARC) audit programme and used this information to inform their practice and make comparisons to the region and national data. The service also monitored practice against the care bundles audits.

Outcomes for patients were positive, consistent, and met expectations, such as national standards. Trust data showed the service was in line with peers for performance across the audits. We saw data for September to November 2021 which showed practice was consistently in line with best practice.

Managers and staff used the results to improve patients' outcomes. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Data was reviewed and used to inform any changes to the service.

Managers used information from the audits to improve care and treatment. We were given examples, of how equipment had been changed in response to an increase in pressure sores to improve patients' experiences.

Managers shared and made sure staff understood information from the audits. Audit information was shared with the team and any plans or ideas for improvements discussed.

### Competent staff

**The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. Managers made sure staff received any specialist training for their role. Trust data showed 42% of staff had completed a critical care speciality course, with an additional three members of staff due to qualify in January 2022. The course had been affected by COVID-19 and the service planned to offer training to at least two members of staff with each cohort. The service also provided emergency care training days which were completed monthly and looked at care of tracheostomies and emergency scenarios.

The service aimed to provided immediate life support (ILS) training to all band 6 and 7 staff and those band 5 nurses who had completed the critical care course. Trust data showed at the time of inspection, overall compliance was 97%, with nursing staff being 63% compliant. The critical care outreach team had advanced life support (ALS) training, as they made up part of the trust wide resuscitation team. Trust data showed that all but one CCOT staff member had ALS training in place with that individual planned to complete training in January. Training had been impacted by COVID-19.

Trust data showed one trust grade doctor had completed advance trauma life support (ATLS) training and was planned to complete ALS training in early 2022. All other training doctors had completed ALS training. No critical care consultant had in date ALS training, although one was planned to become an instructor in 2022.

The practice development nurse (PDN) supported the learning and development needs of staff. The PDN worked with staff to enhance training as well as provided group training and monitored compliance, sending reminders to staff to complete training, as necessary.

Staff told us during the pandemic staffing had been pressured and they had utilised staff from other departments, such as theatres and agency staff. Staff who were asked to relocate to critical care were supported to gain new skills and competencies by completing the critical care skills passport.

# Critical care

Managers gave all new staff a full induction tailored to their role before they started work. All staff completed an induction programme within the service where they were supernumerary. We were told this lasted a minimum of four weeks and was extended as necessary to ensure staff competence. Competencies followed the national critical care standards. Staff were also encouraged to give feedback on their competencies and supernumerary period to enhance the programme for future participants.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. The ward manager ensured there was a band seven nurse available every day to provide support to the team.

Managers supported staff to develop through yearly, constructive appraisals of their work. Trust data showed that 91.5% of nursing and support staff and 100% of critical care outreach staff and medical staff had an appraisal within the last year. 100% of staff had revalidated to the appropriate council. All staff reported they had completed appraisals, and they used reflection to inform their learning when incidents occurred.

Managers identified poor staff performance promptly and supported staff to improve. The ward manager worked closely with the other senior nurses to monitor practice and acted quickly to address any areas of concern. We were given examples of how using an electronic patient record enabled areas of poor compliance to be highlighted quickly and action taken as soon as it was noticed to ensure a speedy change.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. All meeting notes were shared electronically and in paper format to enable staff to see what was discussed at meetings.

The critical care outreach team (CCOT) were responsible for additional skills training across the trust. The CCOT trained ward staff on managing a deteriorating patient, SBAR (Situation, Background, Assessment and Recommendation framework), ALERT (Acute Life-threatening Event- Recognition Training) and resuscitation. We were told some of the CCOT team shadowed shifts within critical care to maintain their skills and competence.

The service did not employ newly qualified nursing staff, as the service felt they required some consolidation of learning before transitioning to critical care.

We were told the unit currently provided one critical care nurse to the surgical inpatient ward, who assisted with the management of patients' post-surgery. This was a rolling position and staff were allocated to the role on the off duty.

### 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 team (MDT) meetings to discuss patients and improve their care. We observed a multidisciplinary team meeting and saw junior doctors presented each patient and then the team discussed the treatment and ongoing care. All staff were included in the discussion and all opinions considered. Nursing staff and junior doctors told us they felt listened too and valued in MDT meetings. The MDT meetings were attended by all medical staff groups, the nurse in charge, named nurse, physiotherapist and if available the pharmacist.

When the named nurse was unable to attend due to the patient being too unwell, the team conducted the meeting by teleconference. This ensured doctors had access to up-to-date information and the most relevant people were included in the conversation. Staff told us this had been introduced during COVID-19 wave one as staff were unable to leave the unit and additional precautions were required to prevent cross contamination.

Nursing staff reported that doctors were responsive to any calls for help, and easily accessible out of hours. Similarly, junior doctors reported that consultants and registrar were always supportive of their concerns or calls for support or assistance.

Staff worked across health care disciplines and with other agencies when required to care for patients. The microbiologist attended the unit daily and completed a review of each patient offering advise with regards to the management of any infections. We also saw that the organ donation nurse attended the MDT and was able to utilise the time to update on the new referral system in place.

### Seven-day services

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

The service was operational seven days per week and flexed the number of beds in use in line with capacity demands. Patients requiring level two or three care could be admitted to the unit following a consultant-to-consultant referral.

The team had access to all services in and out of hours, for example staff could access chest x-rays and all blood testing out of hours if clinically required.

Consultants led a minimum of twice daily ward rounds, including weekends.

The nursing team were supported by a group of specialists including physiotherapists. The team provided treatments Monday to Friday and an on call respiratory rota at weekends and consisted of one band 7, two band 6 and two band 5 physiotherapists who worked across the surgical and critical care.

Staff on wards could call for support from the critical care outreach team seven days a week. The team provided two nurses where possible and ensured at least one nurse was always available.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

**Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.**

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were able to describe the capacity assessment used and when they would complete them.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Those patients who were not sedated were asked to consent or give inferred consent to treatment.

Staff made sure patients consented to treatment based on all the information available. We were told that when patients were unwell and discussions occurred about being admitted to critical care, patients were involved. Where patients were not able to be involved with these discussions, staff consulted family members if possible, or acted in the patients' best interest. Staff clearly recorded consent in the patients' records.

# Critical care

## 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.**

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. Although most patients were sedated, staff were observed to spend time communicating with patients and informing them of activities. Relatives were treated with kindness. All staff reported COVID-19 had impacted the ability for family members to attend the unit. In response to this staff had utilised telephone/video calls to enable loved ones to see their relatives.

All staff ensured patients dignity utilising screens and curtains when care was being provided. Most patients were sedated, but those who were not, were screened from other patients where able.

Relatives said staff treated them well and with kindness. We saw multiple thank you cards to staff from patients and relatives thanking them for their support and kindness.

Staff followed policy to keep patient care and treatment confidential. Staff took care to ensure conversations and discussions were not overheard and had processes in place to ensure information was shared with correct contacts only.

### 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. Staff gave patients and relatives time to ask questions and explained treatments and care. Staff could also access or refer to psychological support staff if necessary, or signpost relatives to support groups. Following discharge from critical care, patients were invited to attend the unit to familiarise themselves with the service to fill in any gaps in their memory.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Relatives were able to use quiet areas for when bad news was given.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff took time to explain key information and then enabled relatives to ask questions.

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. Staff spoke respectfully about patients and relative's experiences.

# Critical care

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs. Staff considered individual needs and where possible took steps to ensure these were addressed. For example, the hospital pastor attended the unit and provided a service/blessing if appropriate.

### 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. Patients and relatives had regular updates on care and treatment, and were involved with planning care, where possible. Staff encouraged relatives to keep diaries which could detail changes to treatment and any updates or questions which could be used to inform discussions, ensuring relatives could ask any questions.

Staff talked with patients, families, and carers in a way they could understand, using communication aids where necessary. Staff used plain and simple language to ensure relatives and patients understood what was happening. We saw staff could access communication aids such as pictorial charts and used these to try and communicate with patients to identify needs.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff encouraged feedback about care and treatment provided through a discharge survey. We saw there were multiple 'Thank you' cards and notes from relatives and patients. The service reported 100% positive friends and family feedback from May to October 2021.

Staff supported patients to make advanced decisions about their care. We saw patients and relatives were given the opportunity to discuss care and if advanced decisions were in place these were followed.

Staff supported patients to make informed decisions about their care. We saw staff explained treatments and potential outcomes with patients and relatives enabling them to make informed decisions.

## Is the service responsive?

**Good** ➔➔

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

### Service delivery to meet the needs of local people

**The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**

Managers planned and organised services, so they met the needs of the local population. The service worked collaboratively with the critical care network and regional peers to alleviate pressures across the system. We heard how the service accepted transfers from other hospitals who were under pressures with regards to the number of patients needing level three care. The service was planning to increase the bed capacity as part of future development plans in response to an increase in local population.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The service was not required to report mixed sex breaches for level two and three patients (those who requiring one organ or more support). However, once patients were fit to be discharged from critical care, mixed sex breaches were considered. The service reported no mixed sex breaches from June to October 2021.

When patients were fit to be discharged from critical care, staff told us they moved the patient to one end of the unit to prevent or reduce the exposure to other patients care and treatment. We saw care was taken to protect patients who were awake from observing care for patients who were sedated.

Facilities and premises were appropriate for the services being delivered. The critical care unit was large enough to meet the current demands of the service, although plans were in place to increase numbers in the future. During the COVID-19 first wave, critical care had expanded into theatres recovery, with additional high dependency beds placed on Sandringham ward, which were managed by the surgical team to enable some operations to be completed.

There were facilities available for patients who were awake, with a nearby bathroom, and staff were able to access entertainment and meals as needed.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff could access specialist teams to support care and treatment. For example, radiology services were able to complete mobile x-rays to prevent patients from being transferred to the x-ray department and speech and language therapists were available to complete swallow assessments. Physiotherapy services provided an on-call services as well as seeing patients routinely in hours.

### 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. They coordinated care with other services and providers.**

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Once patients were transferred to high dependency beds, and were no longer sedated, staff utilised personal preferences to ensure patients were cared for in line with their needs or beliefs and preferences. Carers were able to stay to enable patients with learning disabilities to be cared for by people whom they knew and trusted, although this was impacted by COVID-19. Staff took patient needs into account and where necessary, facilitated additional visiting or carers.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff utilised picture cards to facilitate communication, where able, patients could use a pen and paper to write key words to staff. We observed nurses spending time to ensure they captured exactly what patients were trying to say or asking for. This was completed calmly and with sympathy for the patient's frustration and trying to be understood.

The service had some information leaflets available in languages spoken by the patients and local community. Staff could access translators, if necessary, although leaflets were not generally used within the service.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Patients were not routinely fed whilst in critical care, having nutritional support through other means. Once patients were awake, and cared for on the high dependency unit, staff could access meals suitable to patients' preferences. Additional dietary changes were also considered. For example, some patients required a soft diet due to changes following intubation.

There was a relative's room and quiet room and while there was no outside light or window, extra care had been taken to ensure the environments were as appealing as possible. The service had introduced ceiling lights with outdoor images.

Relatives were not permitted into the unit unless there was a specific need. This had changed during the pandemic, and staff were seen explaining visiting and any additional protection that was required.

### Access and flow

**People could access the service when they needed it and received the right care promptly. The service admitted, treated, and discharged patients in line with national standards.**

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. We saw patients were generally admitted to critical care when they needed level three treatment. There had been no incidents relating to admissions to the department, however, there had been some delays in transferring patients out. Trust data showed there had been 510 admissions to the unit from December 2020 to November 2021. Data also showed there had been two patients readmitted to the service from June to October 2021.

Patients who are deemed fit for discharge and remained in critical care over four hours are deemed a delayed discharge. Records showed 323 patients had been delayed in being transferred out of critical care from December 2020 to November 2021. One hundred and fifty patients were discharged from critical care to inpatient wards between four and 24 hours and 177 patients were discharged after 24 hours. During inspection we saw two patients were awaiting a bed on an inpatient ward during our inspection, one patient had been highlighted as being ready for critical care discharge two days previously and the other patient one day.

The service also reported that sometimes due to the pressures on beds external to the department, they had kept patents and discharged them home directly from the unit. Data showed 30 patients had been discharged home from the unit from December 2020 to November 2021.

Staff were sometimes required to move patients between wards at night. Trust data showed 32 patients were transferred between critical care and inpatient wards after 10pm from December 2020 to November 2021. This was not in line with best practice and was reported as an incident.

Staff supported patients when they were referred or transferred between services. The service reported 28 transfers out of hospital to other critical care units between December 2020 and November 2021. Staff explained that when there were pressures on bed capacity, staff made the decision as to which patient would be the most stable for transferring to another hospital. This ensured the new acutely unwell patient remained at the unit to ensure the transferred patient was as stable as possible. The service reported that they regularly accepted patients from other hospitals across the region.

We reviewed the admissions data for the three months preceding the inspection and saw most patients admitted had been as an emergency and for level two care. Service leads told us this changed according to activity and wider pressures. Staff told us level three patients were rarely cared for outside the critical care unit, however, during wave one of the COVID-19 pandemic staff had flexed areas to meet demands on the service.

# Critical care

Data provided by the trust showed the critical care outreach team saw an average of 612 patients each month from June to November 2021. There had been an increase in numbers noted for September, October, and November with 714, 709 and 962 patients seen, respectively.

Data showed that CCOT saw an even spread of patients during day and night shifts, with most follow up visits occurring in day hours (from 7.30am to 7.30pm). From November 2020 to November 2021, the response time from referral to review was 56 minutes. Staff saw patients' multiple occasions to follow up on their wellbeing, and we saw there were between 406 to 1,039 separate clinical reviews each month for the same period.

Managers monitored patient transfers and followed national standards. Managers monitored admission and discharge times and made sure patients received treatment within agreed timeframes and national targets. The service participated in the Intensive Care National Audit and Research Centre (ICNARC) audit programme which reference performance against national standards. The data was collected on site and reviewed by a clinician to ensure it was accurate before being submitted to the audit. The data was then reviewed and published every three months which enabled oversight of the unit's performance with key indicators, such as admissions, delays in discharge and levels of care provided. Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. Any delays to discharges were recorded as part of the ICNARC data.

Managers and staff worked to make sure patients did not stay longer than they needed to. Patients generally moved to other wards once they were deemed fit to be discharged. However, we were told hospital activity did not always enable this.

The service moved patients only when there was a clear medical reason or in their best interest. Admissions to and from critical care were always completed in line with clinical needs. Consultants reported they had clear discussion regarding end-of-life pathways and tried to have detailed conversations as early as possible to ensure teams knew what was planned. Family expectations were discussed as part of the admission processes.

The team provided a follow up clinic for patients who had been intubated for 48 hours or patients who had been in critical care for five days. Patients received a letter inviting them to attend the clinic, which was followed up by a telephone call if the patient did not respond. This process enabled patients to discuss any ongoing concerns or ask any questions about their care or treatment on the unit. The service was led by a consultant and assisted by staff with an interest.

### Learning from complaints and concerns

**It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.**

Patients, relatives, and carers knew how to complain or raise concerns. There was clear advice for relatives to follow when wishing to raise concerns or make a complaint. Staff could signpost to the Patient Advice and Liaison team (PALS) and clearly displayed information about how to raise a concern in patient areas. However, staff told us they tried to resolve any concerns at the time.

Staff understood the policy on complaints and knew how to handle them. We were told the service seldomly received complaints, although staff knew how to manage or escalate them.

Managers investigated complaints although due to their small numbers were unable to identify any themes. The service had received no complaints from May to December 2021.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We saw complaints were investigated and where appropriate patients or relatives were involved and informed of the findings or outcomes.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff told us they regularly discussed complaints at team meetings and at handovers. This enabled all staff to act on the themes.

## Is the service well-led?

**Outstanding** ☆ ↑

Our rating of well-led improved. We rated it as outstanding.

### Leadership

**Leaders had the skills and abilities to run the service. There was compassionate, inclusive and effective leadership at all levels and leaders demonstrated high levels of experience, capacity and capability to ensure the delivery of an excellent service. Development systems were embedded with clear succession planning. Leaders had a deep understanding of the issues, challenges and priorities of the service and beyond.**

The service was part of the surgical division, with a leadership structure which was replicated across each directorate. Leadership consisted of a clinical director, service manager and nursing lead. They were supported by a ward manager, governance lead nurse, and practice development nurse.

Comprehensive and successful leadership strategies were in place to ensure and sustain the delivery of the service and to develop the desired culture. Service leads understood the issues and challenges of the service and wider organisation and health economy. Leads spoke about how risks and service changes were managed, explaining there was an inclusive approach to managing escalating concerns. For example, earlier in the year, the team were required to relocate in response to concerns with the infrastructure of the department. We were told within a brief period, all service leads met to discuss the risks and agree the safest process for relocating. This resulted in a speedy response and the relocation of all critical care patients to facilitate essential building works.

There was an embedded system of leadership development and succession planning, which aimed to ensure that all leadership represented the diversity of the workforce. Although there were clear roles and responsibilities for everyone, staff confirmed they ensured peers completed tasks to ensure effective management of the team in the absence of any individual. For example, the governance lead nurse was able to cover the ward manager roles in their absence to ensure the effective management of the ward.

There was a rolling band 6 development post which staff were able to apply for as part of their development. This was a six-month secondment which could be extended to 12 months if staff were willing, enabling consolidation of learning. This post gave band 5 staff the opportunity to take on additional roles and responsibilities and to learn about management. They were able to choose a mentor to support them through a defined programme.

# Critical care

During the COVID-19 pandemic, staff had worked across three separate critical care units, which meant some band 5 staff had taken on additional responsibilities as nurse in charge. Service leads explained this had promoted additional confidence in staffs' abilities and had resulted in an increased number of staff applying for the band 6 development secondment.

Staff told us service leads were always accessible and available. Staff spoke positively about their openness and leadership style, and staff felt well supported.

Although leads did not always have clinical roles within the service, we were told they often covered breaks and assisted if there were increased pressures within the service. They supported staff development and encouraged junior staff to take on additional roles to develop their skills both clinically and non-clinically.

Staff spoke positively about the senior leadership team (SLT), staff felt supported and listened to, and reported visibility and easy access. Staff felt confident any areas of concern would be acted upon, although acknowledged that the processes of escalation needed to be followed.

Staff reported that the turnover of SLT members had resulted in some changes to the processes used within critical care. Staff reported they had previously been self-sufficient and were able to arrange funding and changes without too much oversight from SLT. As the SLT had changed there had been additional processes implemented to ensure trust wide processes were followed. Although staff reported this was a good thing, there was an acknowledgement of the impact of change within the unit.

### Vision and Strategy

**There was a clear statement of vision and values, which was driven by quality and sustainability. These had been developed through structured planning processes in collaboration with the service, staff and external partners.**

The service had a local vision which was called ‘our promise to you’ and was displayed in the reception area of the unit. The vision outlined the teams commitment to ensuring patients and their relatives were assured that “everything was being done to keep you safe and to ensure you are receiving the right treatment.” The vision outlined how this was to be achieved and the stakeholders required to ensure the vision was put into action. Staff were aware of the vision and were dedicated to providing the best care possible. Staff had also been involved with the development of the values.

Staff of all grades were also aware of the trusts vision and values.

### Culture

**The service leads had a shared purpose and strived to deliver and motivate staff to succeed. There were high levels of satisfaction across all staff groups and there was strong organisational commitment. Staff spoke highly of the service as a place to work and of the culture. Staff were encouraged to speak up and raise concerns. There was evidence of strong collaboration, team working and support network across all areas, and staff were focused on improving the quality and sustainability of care and peoples experiences**.

Service leads had an inspiring shared purpose and strived to deliver and motivate staff to succeed. There was high levels of satisfaction across all staff. Although the team had been under considerable pressure during the COVID-19 pandemic, staff spoke positively about the experience and what had resulted from the hard work. They explained they had improved working relationships with other departments and specialities, with daily conversations with teams to ensure patients were cared for in the most appropriate area and teams were supported. Leads also explained they had improved relationships with the critical care network and regularly chaired meetings.

# Critical care

Staff spoke positively of colleagues from overseas, who had been prevented from travelling to see their families during the COVID-19 pandemic. Staff were sympathetic to their distress at not being close to families during very difficult times and encouraged staff to be open and seek support where possible. Staff spoke positively about the peer support and utilised pre-pandemic facilities such as the 'caring café' which was a safe place to speak to each other. The 'caring café' had been introduced once per month pre-pandemic but increased in frequency to weekly since.

All staff spoke positively about the multidisciplinary team approach to care and the service. There was evidence that the team collaborated to make plans and improve the service and patients care or experiences. Nurses told us their opinions were sought when caring for patients and doctors treated them respectfully and inclusively. We were given examples of where nurses had raised concerns regarding a patient's withdrawal of care, and doctors took time to explain rationale and openly discussed the concerns without prejudice. Staff felt included and worked collaboratively. Service leads felt that this approach resulted in an improved staff satisfaction and reduced turnover of staff. All staff felt supported and valued by the service leads.

Some staff reported there was less support from the wider team (outside critical care) and although there had been positive changes to the senior leadership team, the 'middle management' level remained unchanged. It was suggested that to improve the pace of cultural change, this level needed further work.

Consultants told us all referrals to critical care were required to be by a consultant-to-consultant referral. The team had introduced a process whereby the consultant would need to have a bedside handover of a patient if there was any concerns or disagreements about the referral. They also adopted the practice that referrals were reviewed by an independent consultant.

Staff told us the team were resilient and had coped "amazingly" during COVID-19 wave one, however, had some concerns for staff from other clinical areas who had been subjected to a different type of nursing. Staff showed empathy and compassion for their peers and colleagues across the hospital who had helped support the delivery of care at a very pressured time.

Healthcare assistants reported they did not attend team meetings as the information was not relevant to their role. They had escalated this to the ward manager who had introduced a healthcare assistant team meeting which focused specifically on their needs and their role. Healthcare assistants reported they enjoyed working on the unit and felt valued and included.

Teams and staff external to the critical care unit reported the team were "exceptional" and innovative, promoting collaborative working.

### Governance

**Governance processes were actively reviewed and reflected best practice. There was a systematic approach to working with other organisations to improve outcomes.**

Governance processes were robust and proactively reviewed to reflect best practice. Performance was reviewed continually, with comparisons made to peers and national standards. There were several meetings which reviewed performance and risk, which had clear escalation points to the trust board and to the team locally. The service held service line multidisciplinary team, team leader and whole team meetings monthly with minutes shared across the whole team to ensure information was shared. Those who did not attend team meetings could access minutes through shared files or printed copies.

We reviewed meeting minutes and saw there were set agenda items and meetings were well attended. There was evidence of clear discussion and agreement on actions to be taken. Action logs recorded nominated individuals for tasks and completion dates which were checked at the commencement of each meeting for progress.

The service had a dedicated governance and risk lead nurse who actively monitored patients records and audit results to identify any areas for additional learning. We heard how data was used to identify any areas of pressure and how action was taken to address them in a timely manner. For example, documentation audits were completed monthly, and data reviewed to enable targeted work. We were told that a trend in lack of recording mouthcare had been highlighted and the governance and risk lead took immediate action to identify the reasons for the oversight. Following discussion with the nursing team it was identified that the wording did not accurately reflect what staff were doing, and this was subsequently changed.

The governance and risk lead nurse produced monthly reports on performance and inputted results into a dashboard, which was used to inform meetings and service planning. The dashboard contained all relevant information to enable informed decision making around the service including, the number of admissions, any delays, bed occupancy, out of hour discharges, readmissions, and elective admissions. The service also used the dashboard to outline performance with patient safety information, such as risk assessment completion, patient experience, and care bundle audit results.

We were also given examples of how the service worked across the region to ensure safe and effective care for patients requiring critical care. Consultants chaired critical care network meetings, and staff participated in regional developments and planning.

### Management of risk, issues, and performance

**Leaders and teams used systems to manage performance effectively. There was a commitment to best practice performance and risk management systems and processes. The service reviewed its performance and ensured that staff had the skills and knowledge to use those systems effectively. Any problems were identified and responded to quickly. They had plans to cope with unexpected events.**

The service demonstrated a commitment to best practice performance and risk management systems and processes. The service had worked with an external company to ensure relevant data could be captured to complete the Intensive Care National Audit and Research Centre (ICNARC) audit programme. This enabled key information to be automatically collected, which was then reviewed by a senior clinician. This enabled data to be confirmed before submitting to the audit programme and prevented queries regarding authenticity of information.

ICNARC data was used along with local audit information to inform decisions about care and service planning. Data was analysed at a service lead level to inform planning and improve performance. We were told staff used audit data to inform decisions about care and target training where necessary.

The service ensured staff at all levels had the skills and knowledge to use the systems and processes effectively. We were given examples of how all staff received training on commencement in post, so they understood the importance of audit and what it showed. By reviewing the ICNARC data, the team were able to identify any issues with individuals' practices, and we were given examples of how they had given additional training to staff to ensure that all data fields were completed accurately.

Training was provided to medical and nursing staff, through standardised processes. Staff followed national guidance for critical care competencies.

The service had a risk register which was reviewed regularly as part of team and service wide meetings. All staff we spoke with were aware of the risks to the service and told us that top risks were delayed discharges, and the lack of a designated pharmacist.

Any high risks were escalated to the trust board for oversight, for example, the issues with the ceiling had been escalated to trust board in advance of any works being completed. Service leads were confident that their performance data was reviewed by the senior leadership team to inform decisions about the service and any risks.

The service leads had a business continuity plan which could be implemented in the event of a major incident. We were told how the team had been tested with the recent move to another clinical area due to issues with the roof, and this had reinforced leads confidence in the abilities of the team to manage major incidents well.

### Information Management

**The service invested in reliable and innovative systems to collect reliable data and analysed it. Staff could find the data they needed, and information used in reporting, performance management and delivering quality care was consistently accurate, valid and reliable. Staff demonstrated a commitment to sharing information proactively to drive and support decision making and system wide working and improvements.**

The service invested in innovative and best practice information systems and process to gather information. Staff told us the service had worked collaboratively with peers across the region to ensure that they all used the same patient information system. This enabled clear analysis across the patch. Staff had also worked with the system developers to ensure that it enabled accurate data collection and analysis to inform other audits and performance analysis.

Staff were provided with training in information management and leads targeted training in response to any findings. Staff told us that information was easy to find, and the electronic system used was user friendly.

Audits results, such as the Intensive Care National Audit and Research Centre (ICNARC) audit programme and care bundle audits were shared in easy read formats to enable understanding. Staff openly discussed results and how performance could be improved. Staff told us by introducing standardised training on commencement in post encouraged a high standard of data input which resulted in quality data. Staff told us they understood the importance of audits and what they showed.

We saw that computers were always locked when not in use and individual passwords were used to access information.

### Engagement

**The service developed through collaboration with internal and external partners using innovative approaches to managing demands. The service takes on leadership roles in the health system to identify and proactively address challenges and meet the needs of the population.**

The service proactively engaged with all staff, including those with protected characteristics to shape the service. Staffs' opinions were considered, and we were told all conversations were inclusive. Staff were fully engaged with the service and positive about their colleagues. Staff reported that some staff had worked within the service for several years and the team were part of the family. There was a closed social media account which was used to share key information about the team.

# Critical care

The service captured feedback from patients and relatives and where possible used information shared through focus groups to improve the service. This had been temporarily placed on hold due to COVID-19, however, the team used follow up appointments and surveys to capture any feedback about the service.

Staff encouraged the use of patient diaries to inform patients of care completed while they were in critical care. We saw staff completed these on the patient's behalf as visiting was not permitted. This ensured patients were able to access information about their care.

Staff reported COVID-19 had assisted with peers across the organisation. Staff told us they had introduced daily meetings with peers in the respiratory medicine speciality to better manage the flow of high-risk patients through the service. Staff felt that COVID-19 wave one had improved understanding across the wider organisation and emphasised the need to work collaboratively.

Service leads had completed a critical care burnout survey in 2019 in recognition to the high risk of burn out amongst the staff group. Following the survey, which was completed in liaison with the mental health liaison team, the service introduced a caring café, which gave staff the opportunity to discuss any concerns in a safe space. The caring café was initially completed monthly, although had been increased to weekly during COVID-19 wave one.

The team also had access to a clinical psychologist who helped them work through any concerns regarding work, particularly after COVID-19 wave one, where staff had been impacted by the multiple patient deaths.

### Learning, continuous improvement and innovation

**There was a fully embedded and systematic approach to improvement, which used recognised improvement methodology. Staff were empowered and supported to lead and deliver research projects to improve patient care or outcomes. Staff innovation was celebrated and new ways of working was shared across the wider health economy.**

There was a fully embedded and systematic approach to improvement, with staff encouraged and empowered to participate in research and manage development projects. The team had introduced several processes or pieces of equipment to improve patient experience and safety. From December 2020 to November 2021, the team had been nominated and won several awards regarding improvements to care and treatment including the:

- Patient Safety Innovation of the Year, at the National Patient Safety Awards 2021
- The John Smith Difficult Airway Society award for the Oxyblade laryngoscopy blade
- Best Regional Anaesthetic Solution, at the Medovate Ltd Healthcare and Pharmaceutical Awards 2020
- Eastern Critical Care, health and Safety Investigation Branch, Human factors

The team had also been nominated for several internal (Queen Elizabeth Hospital) awards including the ‘we listen award,’ ‘we act award,’ ‘we care award,’ the patient safety champion and the clinical team of the year (Critical care outreach team).

The team encouraged staff of all grades to lead on research giving them the opportunity to be authors and present findings at conferences. We heard how doctors were given the opportunity to lead on projects and how some nurses had travelled overseas sharing new practices.

# Critical care

The team celebrated their innovation and successes but considered innovation and research to be part of their daily role. Consultants spoke positively about what they had achieved as a service and continued to plan work collaboratively with peers and staff to identify new and improved ways of working. We were given examples of how the team had led changes to care across the region and internationally, following the development of patient safety devices.