The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

The Queen Elizabeth Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	**Requires improvement**
Accident and emergency	Requires improvement
Medical care	Requires improvement
Surgery	Requires improvement
Critical care	Good
Maternity and family planning	Requires improvement
Services for children and young people	Good
End of life care	Requires improvement
Outpatients	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

The Care Quality Commission (CQC) carried out a comprehensive inspection between the 1 and 3 July 2014. We carried out this comprehensive inspection because the Queen Elizabeth Hospital King's Lynn NHS Foundation Trust had been identified as potentially high risk on the Care Quality Commission's (CQC) Intelligent Monitoring system. The trust was inspected by CQC in August 2013, and was subsequently placed into 'special measures' in October 2013, due to the serious failings identified. We also received some whistleblowing accounts that gave us concerns.

The trust had four outstanding warning notices and eight compliance actions, which were reviewed as part of this inspection. We noted that improvements had been made around consent to care and treatment, care and welfare of patients, nutrition and hydration, incident reporting, respecting and involving service users, complaints, records and co-operating with other providers. However, the service remained non-compliant with the regulations on staffing, support for workers, safeguarding, and medicines management. The risk around medicines management has increased since our last inspection, and was having a moderate impact on the service and patients.

The trust remains non-compliant with the warning notice issued on safeguarding. This is because the trust has failed to improve the training and procedures for undertaking safe and ethical restraint of patients, and, therefore, patients and staff remained at significant risk.

The comprehensive inspections result in a trust being assigned a rating of 'outstanding', 'good', 'requires improvement' or 'inadequate'. Each section of the service receives an individual rating, which, in turn, informs an overall trust rating. The inspection found that overall, the trust has a rating of 'requires improvement'.

Our key findings were as follows:

- In all areas, we found that staff were kind, caring and compassionate towards patients.
- Good progress had been made in strengthening the executive capacity of the board and establishing a pace of change towards improving quality.
- Evident support for the interim CEO's style and influence across the trust, engendering a commitment to change and improvement.
- Staff were proud to work in the trust.
- Patients received adequate nutrition and hydration; however, medical wards, including Pentney, Necton and Oxborough, were reminded of their responsibility around nutrition and hydration needs during the inspection.
- There was a 'disconnect' between the local leadership and the trust board leadership styles, particularly in A&E and in surgery. This meant that communication messages across all areas were mixed and not consistent.
- While risks were robustly identified and placed on the risk register, there was little evidence of any action taken following this identification and recording.
- Resuscitation support, equipment, training and compliance with Resuscitation Council guidance were not consistent in practice or implementation throughout the trust.
- Management of medicines, including storage and recording of temperatures, was not always in accordance with national guidelines.
- Medical staffing levels across the medicine directorate were not sufficient.
- Skill mix across nursing staff required review to ensure that the skill mix was appropriate and to ensure the safety of patients.
- Nurse staffing was insufficient in both the neonatal and the paediatric unit.
- Environmentally, there were concerns with the outpatients department, which required refurbishment improvement.
- The mortuary environment required refurbishment.
- The A&E environment for paediatric care was not in line with national requirements.

Summary of findings

- The elective surgery cancellation rates were significantly higher than expected, and, therefore, the service was not able to meet the needs of the local people.
- Infection control standards and practices around cleaning and equipment were not consistent.

We saw several areas of outstanding practice, including:

- The use and implementation of guideline-specific simplified care bundles through the acute medical unit (AMU) into the hospital, which have improved patient care and patient outcomes.
- The use of 'Project Search', which supports people in the community with a learning disability, to gain work experience and employment, in the community, and within the hospital.
- The endoscopy service, operating a single sex patient list for elective cases.
- The expert support available to babies transferred home with breathing or feeding requirements.
- The initiative of the director of nursing to bring together all nursing leaders across the locality to review issues affecting the quality of services to patients transferring to the independent sector.
- Daily surgical consultant ward rounds.
- The establishment of dementia coaches to supplement the dementia team in supporting patients and families

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Ensure that resuscitation support, equipment and training is consistent throughout the trust, and compliance with Resuscitation Council guidance is achieved. We found several examples of different equipment on resuscitation trolleys, lack of training and audit, especially in A&E and outpatients.
- Ensure that the management of medicines, including storage and recording of temperatures, is done in accordance with national guidelines. We found unlocked medicines storage in outpatients and A&E and medical fridge temperatures not being recorded in medicine and surgery.
- Ensure that patients are protected from the risks associated with the unsafe use and management of medicines, by means of ensuring that appropriate arrangements for the recording and use of medicines are in place. Documentation of the administration of medicines was poor in medicine.
- Review and improve medical staffing levels across the medicine directorate to ensure the safety of patients through education and training.
- Embed skill mix assessments for nursing staff to ensure that skill mix is appropriate and ensures the safety of patients across the hospital, but especially in A&E.
- Review nursing staffing levels in both the neonatal and the paediatric unit to ensure that they meet patient acuity and dependency.
- Improve the environment in the emergency department, including paediatric A&E, outpatients and the mortuary, to ensure the safety and treatment of patients.
- Improve access to training; both mandatory and 'required to undertake the role' to ensure that staff have the knowledge to care for patients, for example those at the end of their life.
- Review the elective surgery cancellation rates and review the elective surgery service demand.
- Review medical leadership for elective and emergency surgery to ensure common patient centred aims and objectives are evident.
- Review and improve cancellation rates within outpatients.
- Ensure that patients are protected from infections by appropriate infection prevention and control practices, especially within the outpatients department.
- Ensure that there are sufficient numbers of staff on duty, who are trained to restrain patients.
- Ensure that patients are discharged in a timely manner across all wards and, in particular, at the end of their life.
- Ensure that an executive director is appointed to champion the end of life services as directed by Norman Lamb MP in his letter to NHS chief executives.

Summary of findings

In addition, the trust should:

- Ensure that all staff work together effectively to enhance the experience of the patients, ensuring effective communication at all levels.
- Ensure that equipment storage, within A&E resuscitation areas, is improved.
- Ensure that the environment and storage of equipment in the neonatal unit is better organised.
- Review the equipment used to transport the deceased from the wards to the mortuary, to ensure that it respects people's privacy and dignity.
- Ensure that there are sufficient numbers of staff who are CBRN trained. (CBRN refers to chemical, biological, radiological and nuclear equipment and policies.)
- Ensure that plans to strategically move over to the national early warning score (NEWS) system are agreed and implemented. (The NEWS system relates to the management of deteriorating patients.)
- Review the availability of hydration on Pentney, Oxborough and Necton Wards.
- Ensure that patients are discharged in a timely manner.

We would normally take enforcement action in these instances; however, as the trust is already in special measures we have informed the regulator Monitor of these breaches, who will make sure they are appropriately addressed and that progress is monitored through the special measures action plan.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Accident and emergency	Requires improvement 	The A&E service required improvement in all areas, except for caring, which was good. Patients commented on the excellent service they received from A&E reception staff. We found that the A&E environment was cramped and made observation of the patient difficult at times. Patient flow was poor, and we found that more work was needed to develop escalation plans and pathways to improve access and flow in the emergency department. Whilst staffing numbers were improving, we found that the skill mix for nursing was poor, resulting in increased pressure on the senior nurses due to the inexperience of a large percentage of recently-recruited junior staff. Staff in all roles put significant effort into treating patients with dignity, and patients felt well-cared for as a result.
Medical care	Requires improvement 	We found the medical unit did not protect patients from avoidable harm as there was no robust system of tracking patients through the hospitals. Patients allocated beds on wards that were not on nominated medical wards were “lost” to the medical directorate staff teams. We found that patients were transferred between wards late at night with no assessment of their individual need. Infection control practices were good. We found that staff were very busy, and many reported doing extra hours to cover staffing shortfalls. Staffing levels were not flexed to meet the dependency of patients. There were significant delays in patient discharge from medical wards, despite use of a discharge lounge, which resulted in insufficient beds to accommodate all the patients within this service. Despite this we found that staff were very caring and compassionate. On some wards, it was clear that leadership was effective by the promotion of good practice. However, this was not common practice across the medical wards. Leadership issues had been identified previously on some wards, and plans were

Summary of findings

in place to address these shortcomings. However, others, due to the number of newly-recruited nurses, and an inadequate skill mix of senior and junior nursing staff, were less effective. There was a lack of action taken to address known risks within the service. These risks include the "lost" patients, lack of implementation of NEWS and the transfer of patients after the hospital transfer deadline. There was evidence of good multidisciplinary team (MDT) working.

Surgery

Requires improvement

The services being delivered in surgery were safe, effective and caring but they were not responsive to the needs of patients. This was due to the practice of bringing day case patients in the day prior to operation or undertaking these patients operations at the end of the list which impacted upon the time they remained in hospital. This also had an impact on the overall capacity of the hospital to treat patients in a timely manner and led to a high number of cancellations of operations. The leadership team within the surgical directorate was disparate which impacted on patient care. We found issues with the privacy and dignity of patients attending for breast care.

Whilst we found minor issues with the documentation of the cleanliness of equipment in general the ward environment was clean. People spoke positively about the staff. Staff treated people with kindness, dignity, respect, compassion and empathy while providing care and treatment.

The trust had a clear vision and credible strategy for each surgical unit. The leadership and culture within the organisation reflected its vision and values, and encouraged openness and transparency. The trust engaged with patients, families, visitors and staff, seeking and acting on their feedback to improve the quality of the service. The service took adequate steps to learn continually and improve, to support safe innovation, and to ensure future sustainability and quality of care. The leadership in the service particularly encouraged staff to be innovative, caring and co-operative.

Critical care

Good

Patients and their families said that staff were attentive and caring. Staff treated people with

Summary of findings

kindness, dignity, respect, compassion and empathy, while providing good care and evidence-based treatment. Staff worked well as a team, felt supported by their line managers, and were highly motivated to provide patients with the best care possible.

The service had a clear vision and credible strategy to deliver high-quality care and promote good outcomes. The service was actively involved in national and local research and audit projects, and demonstrated innovation through involvement in equipment design. The trust engaged with patients and visitors, and acted on their feedback.

The trust's track record on safety was good. There were reliable systems, processes and practices in place to keep people safe and safeguarded from abuse. The trust learned when things went wrong, and improved safety standards as a result. We were concerned that there were no side room facilities for coronary care patients; however, we were reassured that this was already on the service risk register, and that senior managers were taking appropriate action by looking at ways to resolve this issue.
Some outcomes for people using the service were good compared to other services. There were periods in the past year where bed occupancy levels were above the England average. These capacity issues meant that patients were not always cared for in the most appropriate setting for their needs, and elective surgery got cancelled.

Maternity and family planning

Requires improvement

We judged that the maternity service required improvements to ensure that it was responsive to patients' needs and the leadership team addressed the known risks. Whilst both midwifery and medical staffing were below the trust's own minimal staffing establishment levels, the staff undertook additional shifts in order that patients received a safe service. The doctors we spoke with told us that the medical staffing levels impacted on training and personal development. The majority of staff were supported by senior management. However, the obstetrics

team was disengaged, and the doctors told us that communication and support was poor from senior clinicians. The trust had a plan in place to address this.

Policies, protocols and guidance were based on and referenced nationally-recognised guidelines and standards. The trust had robust systems in place for the ratification of new policies and guidance. A variety of quality data was collected and analysed. From the data we reviewed, we saw that the trust was performing within expected limits.

All the women we spoke with told us that they had received good care, and we observed good staff interaction, which was polite and respectful. Women were given the opportunity to be involved in their care, and were given support as required. Two part-time midwives were responsible for caring for all the vulnerable women in the community. There were no individual specialist midwives addressing mental health issues, the homeless, teenage pregnancies and substance abuse. There was no dedicated home birth or midwifery-led service available to women. A water birth was offered to women who were eligible to have a water birth; however, due to staffing levels, this was not always possible. There was only one theatre in the delivery suite. This meant that women who had been booked for an elective caesarean section were often delayed, because emergency caesarean sections and other obstetric emergencies took priority.

Services for children and young people

Good

The service required improvement to ensure that it protected the patients from avoidable harm. Equipment was not always checked, serviced and clean; in particular, the paediatric resuscitation equipment in other areas, such as A&E and critical care. There were areas within the neonatal unit which were cluttered. Nursing staff did not have access to regular clinical and safeguarding supervision. Nurse staffing was insufficient in both the neonatal and the paediatric unit. Staff had access to training, education and support.

There were good working relationships between the NICU and the paediatric service including

multidisciplinary team working. We found that the care and treatment of children, and support for their families, was flexible, empathetic, and compassionate. Staff across the service promoted and maintained the dignity of children. Care and treatment plans were individualised. Needs were assessed, and the care plans reflected the needs well.
There was uncertainty between the staff groups about what the vision for the service was. We saw effective and committed leadership at team and senior clinician level, and staff told us they were generally well supported by their managers.

End of life care — **Requires improvement** 

The palliative care team were stretched and whilst care was in general good the trust is required to make improvements in order that all patients receive appropriate care at the end of their life. All staff received half an hour update as part of their mandatory training on end of life care. Staff did not feel this was sufficient. The palliative care team had been unable to provide bespoke training on end of life care due to staffing pressures in their team. The palliative care team were undergoing a review, but this was taking a long time and had commenced in April 2013. Patient care was seen as a priority, but other important areas such as audit, training and service development had been neglected. There were shortages of medical staff and we found consultants were working on good will and were keeping contact with the ward out of hours and at weekends even when they were not on call.
The trust had withdrawn the use of the Liverpool Care Pathway, but staff were not always clear about what guidance they should have been following.
The palliative care team were striving to follow best practice guidance but they were limited to what they could develop. We saw some excellent multidisciplinary working in the hospital and there was access to seven day palliative care services. End of life services were caring. Patients were treated with compassion, dignity and respect. Patients and relatives spoke positively about their care. Patients and relatives felt involved in their care. The

mortuary staff were respectful to deceased patients and we saw they were sensitive when preparing for the deceased patient to be visited by their relatives or friends.

Staff understood their responsibilities with regard to reporting incidents. Ward areas and the mortuary were found to be clean and staff were observed to use personal protective equipment and wash their hands between patients. Anticipatory medication was being prescribed for patients at the end of life, however staff felt there were sometimes delays in getting medical staff to alter medication or intravenous fluids out of hours. Do not attempt cardio pulmonary resuscitation records were complete and we found evidence that patients or their relatives had been consulted about these decisions. Where patients did not have capacity to make their own decisions, conversations had taken place with their relatives.

There was emphasis on ensuring that patients were cared for at the end of life in their preferred location, however, an audit demonstrated that not all patients had their preferred place of death recorded. Rapid discharge was made available for patients who wanted to leave hospital to die in a different location. There were some good facilities in the hospital such as the sacred space and the facilities for bereaved relatives in A&E, but wards lacked spaces where staff could have private conversations with patients or relatives. The lack of side rooms in the hospitals wards meant not all patients at the end of life could be nursed in a side room.

Staff across the service reported a lack of engagement with senior management and there was no executive director with the lead for end of life care. There was no strategy for end of life care and a review of the palliative care team had been underway for 18 months and had affected the morale amongst the team. There were limited governance systems in place although some audits had taken place and had brought about some improvements in practice. We did find some examples of good leadership and staff were committed to providing high quality care for patients at the end of life. There was some good

Summary of findings

work taking place with one of the Clinical Commissioning Groups to improve the planning for end of life care across primary and secondary care for frail elderly people. The aim of this work was to get a full assessment of the patient with all of the relevant specialities involved.

Outpatients **Requires improvement**

The outpatient department requires improvement due to concerns around infection control and the management of medicines. The eye clinic was poorly signposted, and information was not available in other languages. The staff working in the department were competent and received training as appropriate; however, they were required to manage the clinic and to undertake dressing, some of which were also complex. This led to a shortage of staff in some clinics.

We saw good examples of staff respecting patients' privacy and dignity, and patients reported good experiences of the department. In most specialities, the department was meeting targets, apart from in elderly medicine, which was below the required target. Extra clinics were difficult to hold, as there was limited space within the department. However, the department was well-led by the manager, who supported their staff, and staff felt that they had an opportunity to develop and enhance their skills.

Requires improvement

The Queen Elizabeth Hospital

Detailed findings

Services we looked at

Accident and emergency; Medical care (including older people's care); Surgery; Critical care; Maternity and family planning; Services for children and young people;End of life care; Outpatients.

Contents

Detailed findings

Background to The Queen Elizabeth Hospital

The Queen Elizabeth Hospital is an established 488 bed general hospital which, together with 12 cots in the newly-refurbished neonatal intensive care unit (NICU), provides healthcare services to West and North Norfolk, in addition to parts of Breckland, Cambridgeshire and South Lincolnshire. The trust provides a comprehensive range of specialist, acute, obstetrics and community-based services. The Macmillan Centre provides palliative care for patients with cancer and other chronic illnesses, and the radiology department that is one of only five units to have achieved the Imaging Standards Accreditation Scheme status. The trust also works in partnership with Bourne Hall to bring IVF and fertility treatment locally. The trust achieved Foundation Trust status in 2011.

The Care Quality Commission (CQC) carried out a comprehensive inspection between the 1 and 3 July 2014. The inspection was undertaken because the trust was identified as having elevated risks in haematology mortality and governance. We also received some whistle-blowing accounts which gave us concerns. The trust had four outstanding warning notices and eight compliance actions. These issues were reviewed during the inspection.

Our inspection team

Our inspection team was led by:

Chair: Gillian Hooper, Inspection Chair

Head of Hospital Inspections: Carolyn Jenkinson, Care Quality Commission

Inspection Manager: Leanne Wilson, Care Quality Commission

The team included CQC inspectors and a variety of specialists: nine CQC inspectors, six consultants, a pathologist, a junior doctor, nine nurses - four of whom were head of department, a student nurse, and two 'experts by experience'. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection took place between 1 and 3 July 2014.

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG); Monitor; NHS England, Health Education England (HEE); General Medical Council (GMC); Nursing and Midwifery Council (NMC); Royal College of Nursing; College of Emergency Medicine; Royal College of Anaesthetists; NHS Litigation Authority; Parliamentary and Health Service Ombudsman; Royal College of Radiologists and the local Healthwatch.

We held a listening event on 1 July 2014, when people shared their views and experiences of the Queen Elizabeth Hospital. Some people who were unable to attend the listening event shared their experiences with us via email or telephone.

We carried out an announced inspection visit on 2 and 3 July 2014. We spoke with a range of staff in the hospital, including nurses, junior doctors, consultants, administrative and clerical staff, radiologists, radiographers, pharmacy assistants, pharmacy technicians and pharmacists. We also spoke with staff individually as requested.

Detailed findings

We talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at the Queen Elizabeth Hospital.

Detailed findings

Facts and data about The Queen Elizabeth Hospital

The Queen Elizabeth Hospital is the only hospital location in the Queen Elizabeth Hospital King's Lynn NHS Foundation Trust. The trust achieved Foundation Trust status in 2011.

Data contained within the trust data pack identified two risks and three elevated risks. The elevated risks include in-hospital mortality on haematological conditions, whistle-blowing and a governance risk rating for the regulator Monitor.

There were also risks identified with the NHS staff survey, with the proportion of staff reporting good communication between senior management and staff being worse than expected. A risk was also identified through the GMC around enhanced monitoring of medical staff.

In addition to the risks above, Health Education England identified concerns around support for medical trainee staff throughout the hospital. Concerns were also raised by the local community groups, Healthwatch Norfolk, and the clinical commissioning group, around discharge planning and processes throughout the hospital.

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident and emergency	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Inadequate	Requires improvement	Requires improvement
Critical care	Good	Good	Good	Good	Good	Good
Maternity and family planning	Good	Good	Good	Requires improvement	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients	Requires improvement	Not rated	Good	Requires improvement	Good	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Accident and emergency

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

The emergency department (ED) at the Queen Elizabeth Hospital is also known as the accident and emergency (A&E) department. The emergency department saw 53,467 new patients in the last year, including approximately 5,239 children in the last six months.

During our inspection we spoke with 45 staff, including six ambulance crew members and 27 patients, family members and carers. We visited the A&E department, including the major and minor units, paediatric assessment unit, and waiting areas. We also visited the external GP-led out-of-hours service during an evening visit. We received comments from our listening events and from people who contacted us to tell us about their experiences. We also used information provided by the organisation and information we requested.

We also followed up a recent inspection report by the CQC in August 2013. This included warning notices regarding flow and capacity management in the A&E department, and issues around enough qualified, experienced and skilled staff to meet patients' needs.

Summary of findings

We found that the A&E environment was cramped, and made observation of the patient difficult at times. Patients commented on the excellent service they received from A&E reception staff. Patient flow was poor, and waiting times were above the national average due to capacity constraints. We found that more work was needed to develop escalation plans and pathways, to improve access and flow in the emergency department.

Whilst staffing numbers were improving, we found that the skill mix for nursing was poor resulting in increased pressure on the senior nurses, due to the inexperience of a large percentage of recently recruited junior staff. There was also a lack of staff engagement to support staff development and ensure effective practice at all times.

Staff we spoke with knew how to report serious incidents, whistle-blow or challenge, if they suspected poor practice which could harm a person; however, they did not always receive feedback on incidents they had reported; neither were there systems in place to ensure they learnt from serious incidents and 'never events' to improve patient safety. ('Never events' are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.)

We found that there was no clear assurance that paediatric resuscitation equipment was checked as the

Accident and emergency

lead responsibility or ownership for maintaining the paediatric resuscitation equipment was divided amongst many departments. The environment in the paediatric resuscitation area was small and cluttered, but staff were confident that this did not impact on patient care. These concerns were raised with the trust at the time of inspection.

Staff in all roles put significant effort into treating patients with dignity, and patients felt well-cared for as a result. Staff responded compassionately to pain, discomfort, and emotional distress in a timely and appropriate way. We spoke with 27 patients, families and carers, and received positive feedback from a majority of the people we spoke with.

Staff were clear on the known risks that needed improvements, but they did not feel engaged or empowered to make changes to improve the quality of service. The majority of staff noted that the current demands of the day-to-day operational management of the emergency department prevented opportunities for innovation and sustained improvement at this time.

Are accident and emergency services safe?

Requires improvement

Services in A&E require improvement to ensure that patients are safe. We found that the A&E environment was cramped, and made observation of the patient difficult at times. Whilst staffing numbers were improving, we found that the skill mix for nursing was poor resulting in increased pressure on the senior nurses due to the inexperience of a large percentage of recently recruited junior staff. There was also a lack of staff engagement to support staff development and ensure effective practice at all times.

We found that there was no clear assurance that paediatric resuscitation equipment was checked as the lead responsibility or ownership for maintaining the paediatric resuscitation equipment was divided amongst many departments. The environment in the paediatric resuscitation area was small and cluttered, but staff were confident that this did not impact on patient care. These concerns were raised with the trust at the time of inspection.

Incidents

- As a result of the previous concerns identified during inspection by CQC, the adverse incident review system had been revised. An Incident Review Panel had been established, meeting weekly. All incidents graded moderate were reviewed by the panel, and further investigation requested where required. We saw two recent investigation reports for A&E, which were of a satisfactory standard.
- Senior staff were confident to report serious incidents, whistle-blow or challenge if they suspected poor practice which could harm a person. We found that junior staff were not as aware, although they understood the incident reporting procedure. Staff informed us that they did not always receive feedback when they raised concerns, especially regarding vulnerable adults.
- We saw that medical staff were well informed through regular teaching sessions regarding serious incidents, lessons learnt and practice changes to avoid a reoccurrence. However, junior nursing staff we spoke

with were poorly informed, and there was no formal system in place, such as regular unit meetings, to ensure they learnt from serious and 'never events' to improve patient safety.

Safety thermometer

- We looked at the 'Emergency Services Clinical Indicators' for March 2014, and found that the senior nurses within the department were not aware or had sight of this clinical information. They had not submitted any statistics for comparative analysis to support patient safety practices, such as number of falls, drug errors and deteriorating patient scores.
- We found that the senior nursing staff had recently created their own local monitoring tool, but it was not consistent with the rest of the emergency services or visible for shared learning.
- Achieving the '15 minute to nurse triage' target was recently at 80%, and 'one hour to see a doctor assessment' was at 70%, due to no cubicles being available in which patients could be seen.

Cleanliness, infection control and hygiene

- We viewed an infection control audit completed in May 2014, which showed 100% compliance with hand hygiene, care of urinary catheters and peripheral cannula, and there had been no recently reported infections.
- Staff and patients were satisfied with the cleanliness levels throughout the department and we observed staff being compliant with key trust policies, such as 'bare below the elbows'.
- We observed inappropriate use of open sharps bins for empty intravenous bags, which included sharps covered with a sheet. One bin we observed in resuscitation was stored on the floor, which is not in accordance with national guidance.

Environment and equipment

- register regarding children over the age of 10 waiting in the adult waiting area, due to the lack of a specific children's A&E department.
- The paediatric treatment area was small and a significant distance from the resuscitation room, although staff told us that they risk assessed to ensure any seriously unwell child would not be compromised. We checked, and there had been no incidents that demonstrated any patient had been harmed; however, it was acknowledged that the environment required improvement.
- The environment in the paediatric resuscitation area was small and cluttered, but staff were confident that this did not impact on patient care. These concerns were raised with the trust at the time of inspection.
- The paediatric staff member we spoke with could not locate a specific needle or human albumin when asked by an inspector. These concerns were raised with the trust at the time of inspection.
- We raised concerns that staff were not always following the Standards for Clinical Practice and Training in cardio pulmonary resuscitation. These standards make clear that "the choice of resuscitation equipment should be defined by the resuscitation committee". The resuscitation officer stated that they had no say in the equipment for paediatrics. We were told that the anaesthetists chose and maintained the airway equipment, and the nurses told us that they checked only some of the equipment, as the anaesthetists checked the airway equipment. There was no robust system to assure that checking of the equipment took place.
- A new and improved observation facility, for patients staying up to 23 hours in the department, was in place, but not in use at the time of our inspection, due to lack of staff to manage it.

Medicines

- Staff we spoke with were aware of medicine management policies for reference purposes.
- We saw that locks were installed on all cupboards containing intravenous fluids, and monitoring systems were in place to pick up medication errors.

Records

- We noted that electronic records management was being developed in the A&E department. We examined six patient records, which showed that notes were recorded partly on paper and part electronic system. With the aid of staff, we looked at vital signs documentation, which was fragmented and made it difficult to pathway track, to ensure patients were monitored appropriately.

Accident and emergency

- Recent A&E documentation audits were scoring between 88% and 91% compliance, with actions noted to improve record management standards, although we noted that early warning signs audits were not being actioned.
- The records of patients admitted from A&E to the medical assessment unit (MAU did not arrive in a folder. It was reported to us that essential information, such as the results of crucial tests, was often missing.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

- Some staff spoken with had attended mental capacity training. The records observed indicated recent attendance from 65% nursing and 30% medical staff.
- We saw appropriate mental health referral practices, and staff were familiar with consent and mental capacity assessment procedures.

Safeguarding

- We saw meeting minutes that demonstrated that the department sister and the paediatric lead had attended safeguarding meetings. We noted that staff currently trained, as at 30th April 2014: level 1 100%, level 2 99% and level 3 91%. This equates to an overall 94% of all staff trained in safeguarding children. The minutes also noted that the trust was facing challenges because of a shortage of nursing paediatric staff within the department.
- We saw that staff understood about protecting children and vulnerable adults. They had raised concerns about the adolescent group, especially in the waiting areas, with people intoxicated with alcohol, which was on the trust risk register; and staff gave examples of raising safeguarding referrals for vulnerable adults.

Mandatory training

- Staff confirmed mandatory training was provided on a regular basis, although due to capacity and staffing numbers in the department, they could not always attend planned events. We looked at the training records, and there was a monitoring system with traffic light flags to highlight low attendance, such as health record keeping and consent attendance.

Management of deteriorating patients

- Senior staff we spoke with had concerns regarding the high number of junior staff, including overseas staff, in the department, who had limited experience in recognising and monitoring the deteriorating patient. Whilst we were told there was continued education on early warning systems, we did not see specific evidence to support that staff had received this.
- We saw and staff confirmed that there was pressure on the Band 6 staff to continually lead on triage and resuscitation procedures without, at times, strong support, due to the inexperience of junior staff in the management of the deteriorating patient.
- Ambulance crews told us that the pre-alert calls were not always handled appropriately, and this was supported by a recent incident, where a response team was not standing by to receive the patient on arrival.

Nursing staffing

- A skill mix review in January 2014, noted the emergency department currently benchmarks poorly with other similar departments, in that it relies on Band 6 staff to co-ordinate the department. The recommendations for the department were for an increase in establishment by 33.74 whole-time equivalent (WTE). Numbers were linked to professional guidelines and an adapted 'Baseline Emergency Staffing Tool' (BASE), but further work was required before approval could be sought by the board.
- Active recruitment to the emergency department was ongoing, and had resulted in 25% junior staff being appointed. Whilst this has improved the numbers of staff in the unit, it has also resulted in an unbalanced skill mix, which could potentially impact on patient care.
- A consultant nurse was recruited six months ago; feedback from both medical and nursing staff is that this was a good appointment. Initiatives were being actioned to improve standards, such as revised handover times, and review of patient flow systems to improve access. A recent appointment of a matron had resulted in improved monitoring systems to measure the effectiveness of care in the department.
- There was a high use of agency staff who were regular and therefore familiar with the unit. We checked with staff and inductions were being provided.

Medical staffing

- Medical staffing levels were satisfactory, although three consultant locums were currently in place, and the training provision by the trust, for regular medical locums, was not sufficient.

Accident and emergency

- The consultant cover was provided daily, from 8am until 10.30pm, which supports seven days a week working practice.
- The provider received feedback in January 2014 from the Local Education and Training Board, observing that the hospitals training environment for doctors was good, and that 'handover' was clearly improved. Three doctors we spoke with confirmed this.

Major incident awareness and training

- There were clear, up-to-date policies in place for staff reference regarding Emergency Preparedness Resilience and Response Policy (EPRR). There was also a major incident plan in place. Staff spoken with were aware of the process.
- We were informed that the department had recently undertaken an exercise to erect the decontamination tent outside the department. This tent would be used to decontaminate patients and others prior to entering the department. The test identified that the service did not have a sufficient number of trained staff to use the chemical, biological, radiological and nuclear (CBRN) equipment. Further training of staff was being provided; however, further work was required to ensure that the department was sufficiently prepared for a major incident.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

We saw that there was a multidisciplinary collaborative approach to care and treatment that involved a range of providers across health and social care systems, including meetings to discuss specific cases. There was adequate access to both medical and clinical leads to support a seven day a week service.

We found that both local and national audits required development, to show that evidence-based care and treatment was in line with recognised guidance, standards and best practice.

Evidence-based care and treatment

- We found that both local and national audits required development. Currently, only two of the six national audits had been actioned, and the unit could not demonstrate systematic processes for implementing and monitoring the use of best practice guidelines and standards.
- We looked at resuscitation, the fractured neck of femur pathway, and management of the deteriorating patient, and found that robust monitoring, to measure how current practice impacts on care and treatment outcomes, was not in place.
- The recent Emergency Care Intensive Support Team (ECIST) report dated February 2014 noted that the use of 'care bundles' was impressive, and leading to improvements in quality and safety for patients.

Pain relief

- We looked at pain score records and there were omissions. The matron could show recent monitoring of pain scores and some actions noted to improve practice.

Nutrition and hydration

- Patients and staff were positive regarding the offer of fluids and appropriate food in the unit by the house keepers. We observed fluids being offered, and saw it was recorded in the patient record.

Patient outcomes

- We noted that the unplanned re-attendance rate to the emergency department within seven days was significantly lower than average. However, attendances resulting in admission were significantly higher than the national average. At the time of our inspection, it was not clear why the service was higher than the national average, and further work is required around this.
- The number of ambulance handovers delayed over 30 minutes during the winter period of November 2013 to March 2014, compared to all trusts in England, was within the expected standard.
- We were informed that due to staffing issues and patient flow within the department, the fractured neck of femur pathway was not always followed. The recent National College of Emergency Medicine audit highlighted pain management as below standard for this group of patients, which means that patients may not be being treated in line with national guidance, which can affect their outcome.

Competent staff

- We recognise that the trust is actively recruiting to the emergency department. However, there were concerns

raised by staff regarding the high number of new nursing recruits (25%) who have been qualified less than six months. This had put additional pressure on senior staff. There was also a high number of overseas recruits (25%), where English is not their first language, which had caused concerns in the department. We were informed that English language lessons have been provided by the trust to address this.

- The emergency workforce scorecard for March 2014 showed that 90% of staff had received an appraisal. Whilst the majority of staff confirmed they had received an appraisal, nursing staff we spoke with noted a lack of team unit meetings for junior nursing staff and two staff told us that clinical supervision was not provided although plans were in place to introduce it shortly. This was a requirement of the warning notice issued in August 2013. Medical staff received regular training sessions, although the regular locum doctors training support was not clear.

Multidisciplinary working

- Staff spoke positively regarding the emergency nurse practitioners (ENP) support and triage practices, which had resulted in ENP management of 20% attendances in the department, reducing the pressure on the doctors.
- Access to mental health support and a children's mental health referral pathway was available.
- We saw good examples of multidisciplinary working with the rapid assessment allied health professionals team, who work closely with the department to support admission avoidance practices. The recent emergency care intensive support team (ECIST) report acknowledged the excellence of the role of this team as good practice.
- We spoke with the GP out-of-hours service, who noted a good relationship with the department, with appropriate referral systems in place to reduce unnecessary attendances in the emergency department. The nearest urgent care centre was in Norwich.

Seven-day services

- We checked the rotas, and spoke to the medical team and senior nurses, who could show that there was a seven day working approach, and that appropriate medical cover was in place, including out of hours and weekends.

Are accident and emergency services caring?

Good

Staff in all roles put significant effort into treating patients with dignity, and patients felt well-cared for as a result. Staff responded compassionately to patient's pain, discomfort, and emotional distress in a timely and appropriate way.

We spoke with 27 patients, families and carers, and received generally positive feedback from them all on the care and information provision in the A&E department.

Compassionate care

- We observed staff interactions with patients and families in all areas, and found that they put significant effort into treating patients with dignity, and patients we spoke with felt well-cared for as a result.
- Patients told us that staff responded compassionately to their pain, discomfort, and emotional distress in a timely and appropriate way.
- The national inpatient survey indicated a slow response to answering the call buzzers; no concerns were raised during the inspection. The department scored similar to other trusts on dignity and privacy requirements.

Patient understanding and involvement

- We spoke with 27 patients, families and carers, and received generally positive feedback from them all on the care and information provision in the emergency department.
- Patients, relatives and carers described feeling involved in planning their care, and making decisions about the choices available in their care and treatment.
- The Friends and Family Test report showed that over 48% would recommend the emergency department to family and friends.
- The receptionists we spoke with were knowledgeable about the booking systems and risk assessment processes. We saw that they provided good information to people, and they were clear about notifying staff if they thought a patient needed urgent attention.

Accident and emergency

Emotional support

- We saw that space had been created, and a room for bereaved relatives with a viewing facility was now in place. This meant that families had privacy to grieve, and their emotional needs were respected.
- We noted that patient confidentiality was maintained in verbal communication, during discussions, and in written records.
- We reviewed a mental health referral record, and could see that appropriate care and explanations had been provided to the patient.

Are accident and emergency services responsive to people's needs?
(for example, to feedback?)

Requires improvement

Patient flow was poor at times, due to the ongoing high hospital bed occupancy, causing a backlog in the A&E department. Patient flow was poor, and waiting times were above the national average due to capacity constraints. We found that more work was needed to develop escalation plans and pathways, to improve access and flow in the emergency department.

Staff were responsive to people's individual needs, but the majority were poorly informed on complaints and concerns raised by the public, and any responses made to improve the service. Many patients commented on the responsiveness of the reception staff, with this observed as being commendable given the environment.

Service planning and delivery to meet the needs of local people

- We were informed that the trust was taking a range of actions to improve flow through the emergency department, to reduce demand, and to therefore address capacity constraints that may lead to difficulties for staff in maintaining patients' privacy and dignity whilst carrying out procedures. In agreement with commissioner colleagues, the trust had co-sponsored a bid against the national winter pressures monies, released by central government. If successful, the trust will be able to address, within the next three months, the option of increasing assessment capacity within the department, by utilising modular building.

Access and flow

- Staff told us that currently patient flow is poor at times, due to the hospitals high bed occupancy causing a backlog in the department.
- The percentage of patients seen within four hours often did not meet the national four hour standard (across attendance types); we noted that there were 44 breeches during the inspection.
- We found that the total time in A&E was consistently higher than the national average.
- Emergency admissions through the department, where waiting was between four and 12 hours, were also often higher than the national average.
- Percentages of patients leaving before being seen, and the unplanned attendance rate within seven days, were lower than the national average.
- Escalation plans and pathways were not fully implemented or embedded to support access and flow in the department. The ECIST report noted that "many of the features of best practice that we expect to see in Emergency Departments have yet to be piloted, including Rapid Assessment and Treatment (RAT) process".

Meeting people's individual needs

- Staff told us that there was a learning disabilities (LD) lead nurse to support patients and train staff. We saw minutes which showed an active and well supported LD steering group, to support people's individual needs.
- The staff survey action plan noted that a specific course had been introduced, with regard to dementia awareness, as part of the mandatory training programme, and compliance was being monitored. Training records showed eight security team members had attended in November 2013.
- Translation services were available and posters were in place to advise people, where English was not their first language.
- We noted there was a dedicated equality and diversity intranet area, providing information for employees, and the annual report noted that the hospital was meeting the requirements of the Public Sector Equality Duty.

Learning from complaints and concerns

- Staff we spoke with were not able to give examples of complaints and practice changes, as staff engagement through team meetings, information sessions, or

training sessions were minimal. We saw training records where attendance at complaints training for both nursing (21%) and medical staff (15%) was low and required improvement.

Are accident and emergency services well-led?

Requires improvement

Staff were clear on the risks, and areas in the emergency department that needed improvements, but they did not feel engaged or empowered to make changes to improve the quality of service. Staff we spoke with could not articulate the strategy of the hospital, or discuss long-term plans for the emergency department.

Whilst the trust supported the active recruitment campaign, the staff told us that the pace to secure an appropriate skill mix was too slow. The majority of staff noted that the current demands of the day-to-day operational management of the emergency department prevented opportunities for innovation and sustained improvement at this time.

Vision and strategy for this service

- Staff we spoke with could not articulate the strategy of the hospital, or describe long-term plans for the emergency department.
- We found that staff did not speak of the vision and values, and they did not indicate a sense of pride and identification. Overall, the morale in the department was low.

Governance, risk management and quality measurement

- Staff were clear on the risks, and areas in the department that needed improvements, but they did not feel engaged or empowered to make changes to improve the quality of service.
- There was consistency between what frontline and senior staff said were the key challenges faced by the service. The risk register reflected what individuals raised as their key concerns for the service.
- The senior staff recognised the importance of providing high quality clinical and operational information, to support decision-making and delivery of care. However, the current systems to produce it, such as data analysis, audit and clinical indicators, were not robust.

Leadership of service

- The senior managers in the emergency department understood the current and future needs of the service, including the number of leaders, qualities and skills required. Whilst the trust supported the active recruitment campaign, the staff told us that the pace to secure an appropriate skill mix was too slow.
- Staff told us that they felt valued by leaders in the service, but not by the organisation. We found that there was a disconnect between the local leadership and the trust board. This meant that the messages of leadership throughout the service were not clear, and also that staff were not always supported.

Culture within the service

- Due to the current issues in A&E around capacity, flow and staffing concerns, we found that the staff were inward looking, reactive and did not feel empowered to change practices. They said that they felt isolated from the rest of the hospital.
- Concerns were raised regarding the instability of leadership at the top of the organisation. Whilst the chief executive officer was approachable, he was an interim appointment, and therefore staff were not confident regarding sustainability and long-term planning to improve services.
- Staff indicated a blame culture; one member said, “it feels like them and us. We get the blame for poor patient flow when the solution is out of our hands”.

Public and staff engagement

- Senior staff were aware that more work is required to engage patients to complete the Friends and Family Test. A recent review showed a response rate of just 10%.
- Formal staff engagement systems were poor, although staff spoke positively regarding the new nurse managers, and said they were approachable if they had a concern.

Innovation, improvement and sustainability

- The hospital is supported by another hospital, through the buddy system established following the trust going

into special measures. We found that some staff had been given the opportunity to visit the buddy hospital. However, staff we spoke with were not aware of any practice changes or innovations resulting from this.

- The majority of staff noted that the current demands of the day-to-day operational management of the emergency department prevented opportunities for innovation and sustained improvement at this time.

Medical care (including older people's care)

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

Information about the service

We inspected medical care (including older people's care) at the Queen Elizabeth Hospital, where we visited seven acute medical inpatient wards that had a total of 283 beds. We inspected a range of specialty-based wards, including stroke care (West Raynham Ward), gastroenterology and isolation (Stanhoe Ward), Oncology (Shouldham Ward), and elderly care (Necton Ward). We also looked at general medical wards, the medical admissions unit (MAU) with short stay, the endoscopy unit, the outpatient chemotherapy unit, and the discharge lounge.

We spoke with 27 patients and their relatives over the course of the two day inspection, and reviewed information from interviews and discussions, as well as listening to patients' accounts, during the listening event we held in the local community. We also reviewed 21 sets of patients' notes, including treatment charts, and all patients with a 'do not attempt resuscitation' (DNAR) order on the MAU.

We spoke with 66 staff in different roles and grades across the medical wards and departments. We observed care and treatment, and looked at care records. We also reviewed the trust's performance data.

Summary of findings

We found the medical unit did not protect patients from avoidable harm as there was no robust system of tracking patients through the hospitals. Patients allocated beds on wards that were not on nominated medical wards were "lost" to the medical directorate staff teams. We found that patients were transferred between wards late at night with no assessment of their individual need. Infection control practices were good.

We found that staff were very busy, and many reported doing extra hours to cover staffing shortfalls. Staffing levels were not flexed to meet the dependency of patients. There were significant delays in patient discharge from medical wards, despite use of a discharge lounge, which resulted in insufficient beds to accommodate all the patients within this service. Despite this we found that staff were very caring and compassionate.

On some wards, it was clear that leadership was effective by the promotion of good practice. However, this was not common practice across the medical wards. Leadership issues had been identified previously on some wards, and plans were in place to address these shortcomings. However, others, due to the number of newly-recruited nurses, and an inadequate skill mix of senior and junior nursing staff, were less effective. There was a lack of action taken to address known risks within the service. These risks include the

Medical care (including older people's care)

"lost" patients, lack of implementation of NEWS and the transfer of patients after the hospital transfer deadline. There was evidence of good multidisciplinary team (MDT) working.

Are medical care services safe?

Inadequate

Medical care services failed to protect patients from avoidable harm because of a lack of medical and nursing staff, poor identification and treatment of patients who were not on medical wards and lack of identification of patients who may be deteriorating. Medical and nursing staff were observed to use hand sanitising gels and hand washing facilities appropriately. Equipment was generally clean and appropriate; however, curtains in ward areas were not always clean. There was a medical equipment library, where equipment not in use was cleaned, stored and maintained. This meant equipment was available when required.

Doctors told us that there were not enough doctors to complete the rota, and there was a reliance on locums for all grades of doctors. There was particular reliance on locums to fill gaps at junior doctor level, at short notice. Nursing staff told us that they did extra hours to make up the shortfalls and again, there was a reliance on temporary staff. Concerns were also raised about staffing levels and the skill mix on a number of medical wards. The trust was mainly meeting its targets for mandatory training within the medical directorate, the exceptions being infection control training, resuscitation, and moving and handling.

There was no robust system in place for review of medical 'outliers'. These are patients who are admitted to a ward that does not specialise in the condition they have. This often happens when the hospital is at, or near, capacity; for example, medical patients admitted to a surgical ward. This meant that patients were not reviewed promptly and regularly. Staff reported to us that it was often difficult to get outliers reviewed.

Patients were often transferred from A&E and the MAU to wards as outliers. There was no system in place to track these patients' whereabouts. During our inspection, there were 17 outliers on day one, and 21 on day two. During our inspection, two patients got 'lost'. Although they had been admitted to the hospital, there was no system in place to immediately identify where they were.

Medical care (including older people's care)

Nursing records for assessing risks to patients were completed in the care records we viewed, across all ward areas where we visited. However there had been no date set to move to NEWS, the national early warning system, despite this being available for many months.

Incidents

- There had been one recent 'never event' in relation to the medical directorate. ('Never events' are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.) There had been a root cause analysis, and a report sent to the Quality Committee and the Medical Director. We spoke with some staff who were aware of learning from this incident, although many were unaware. The number of serious incidents reported, was in line with expected levels for the size of the trust.
- The medical care services accounted for the highest number of reported patient safety incidents for the hospital within the previous year. This was expected with medical services being the largest inpatient service within the trust. We found that the number of accidents and falls were below the national average for a trust of this size. The highest number of incidents surrounded pressure ulcers. Work was ongoing in reducing these, with the tissue viability team working with the ward staff to educate and support them. Reports showed that incidents of pressure ulcers were reducing. For example, West Raynham Ward, which specialised in the care of stroke patients, had the last 93 days free of hospital-acquired pressure ulcers.
- Serious incidents were investigated, and root cause analysis investigations were carried out. The results were disseminated to staff through meetings. However, many staff told us they were unaware of learning from incidents.
- All staff we spoke to stated that they were encouraged to report incidents using the 'Datix' system. Some staff commented that they only received feedback if the incident was 'very serious'. The majority of staff we spoke with felt that improvements were needed in feeding back from incidents that occurred within the medical wards.

Safety thermometer

- Safety thermometer information was clearly displayed in each ward. This included information about falls with harm, new venous thromboembolism (VTE), catheter use with urinary tract infections (UTIs), and new pressure ulcers. The information was updated regularly. The trust was performing better than the expected range for these measures, except for pressure ulcers and new VTEs.
- Risk assessments for the above were being completed appropriately on admission, and prophylactic treatments were provided to reduce the occurrence of VTEs.

Cleanliness, infection control and hygiene

- Ward areas appeared clean. We saw that some equipment had dated 'I am clean' stickers that evidenced when equipment was last cleaned. However, this was not consistent throughout every area, or with every piece of equipment we saw.
- Curtains in all areas were of a non-disposable type, and were changed and washed above 80 degrees if there was an outbreak of infection, or if they were visibly soiled. However, a member of the infection control team told us that this was done by the housekeeping department and they were unsure how often the curtains were changed routinely. We saw one curtain that was visibly soiled, which the staff arranged to change immediately when we made them aware. Therefore, we were not assured that there were robust infection control procedures in place as regards curtains.
- Patients and their relatives who we spoke with said that the wards were regularly and thoroughly cleaned. People spoken with commented that the wards were clean; one person was quoted to describe them as "extremely clean".
- There was hand wash and hand sanitising gels available throughout the wards. Information was available to remind staff and visitors of the importance of good hand hygiene, so as to minimise the risk of infection. 'Bare below the elbow' policies were adhered to by staff. We saw no staff wearing inappropriate jewellery.
- There were a number of audits carried out by the infection control team, of the environment, and of care, such as cannula insertion. The audits showed that the service was improving on infection rates however the service required improvements when isolating patients identified as at risk of infection or spreading of infection.
- MRSA rates for the trust were within expected limits until late 2013 when there had been a C.difficile outbreak; 30 patients contracted the infection, compared to nine in

the same period in 2013. Although a root cause analysis had been undertaken, it had not been possible to identify the cause of the outbreak. During our inspection we found that since the outbreak the number of patients with C.difficile was within the expected range.

- All wards reported to us that there were not enough side rooms and isolation rooms. Some wards only had two. The staff explained that this caused difficulties when considering patients with different needs. For example, often people who were seriously ill, or receiving end of life care, were not able to be in a side room, as these were mostly used for patients with infections. Or, patients were nursed in a side room to prevent mixed sex bays on the ward.
- We visited Stanhoe Ward, which had a dedicated isolation unit, containing single rooms with en-suite facilities. All patients who had an infection, which was at risk of being passed on to others, were isolated. All types of patients were cared for in the unit, including those who had poor immunity that required them to be isolated from infection from external sources. The isolation unit was flexible, and could be divided into various sizes, so that patients could be cared for individually or in cohorts, depending on their type of infection.
- We saw two completed intravenous (IV) infusions of antibiotics, which had been disconnected from the cannula and left hanging on the stand by the patient's bedside. The infection control nurse consultant told us that the trust policy was for these to be discarded once used, and therefore the policy had not been followed.

Environment and equipment

- Equipment was appropriately checked, and cleaned regularly, in most of the areas where we visited.
- Resuscitation trolleys and equipment were checked and records were kept.
- All sharps bins were dated, signed, and were not overfull.
- We saw a commode on Pentney Ward, which had a piece of paper stuck on it, marked 'broken'. It was unclear what the issue was, and the staff did not know what was wrong with it, or when it would be taken for repair.
- We visited the equipment library. All medical equipment was stored there to enable it to be cleaned, tracked and maintained.

Medicines

- On Pentney Ward we observed medicine administration, with a nurse assisting two people with their medicines, having placed their medicines in front of both of them before first completing one person's medicines. The nurse informed us that a medicine that was needed for the round could not be located in the medicine trolley. On examination, we found that the medicine trolley was poorly organised in that individual patients' medications were not stored together.
- We examined prescription charts on Pentney Ward, and found gaps in records for medicines prescribed for regular administration. The nurses we spoke with reported changes to the coding system on charts to show when medicines had not been administered, and the code for non-availability of medicines was removed. Therefore, it was unclear from the records why medicines were not administered. Evidence from prescription charts showed how medicines being unavailable had led to missed doses. The ward sister confirmed that a recent audit identified approximately 40 omissions, and action had been taken to improve availability of medicines.
- People self-medicating (people who take their own medications whilst in hospital) do not have access to their medicines, except when nurses unlock and open their cabinets.
- Across the service, we found that fridge temperatures and room temperatures were not being recorded consistently. This places the integrity of the medicines at risk, and does not meet national guidelines for the storage of medicines. However the trust stated that they had approved a centralised drug fridge monitoring system which was to be installed in October 2014
- On the MAU, we found that IV fluids and medicines were kept securely; however, the combination code of the keypad had not been changed recently. Staff on the ward reported good pharmacist and pharmacy technician input. However, when we examined prescription charts, the records showed missed doses of regular prescribed medicines for 24 hours or more after a patient's arrival. This included pain killers, anticoagulants and antibiotics.
- In the discharge lounge, we were informed by staff of discharge delays due to medicine supply; these are related to both prescriber and supply delays. We were

told that the time taken was reported to be from between 40 minutes to three hours for medicine supply. We observed this area and found that what we had been told occurred often.

Records

- All records were in paper format. Nursing notes were generally kept at the end of patients' beds, and medical notes were stored in trolleys on the ward areas.
- Healthcare professionals completed specified areas of both nursing and medical records. There was work underway to integrate the notes, so that they were all in one place. Stanhoe Ward had their key documents in different coloured folders, so that they were easily identifiable.
- The consistency of record keeping varied within ward areas, and across the medical wards we visited. Some were well organised and easy to find. Others were more disordered. However, all nursing assessment forms were in one booklet, which was consistent over the whole trust.
- Admission checklists and patient safety checks were consistently completed, and risks around falls, venous thromboembolisms, and moving and handling, were consistently assessed. Assessments, in relation to patients' capacity to make decisions, were routinely completed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were consented appropriately and correctly where people were able to give their consent to care and treatment.
- We examined the training matrix provided by the trust, which showed that approximately 70% of staff within the medical directorate had completed training regarding the Mental Capacity Act 2005, which was within the trust's target. However, only 60% had completed training in consent, which was below the trust's target.
- Patients' capacity to make decisions was assessed as part of the nursing assessment on admission to wards. We saw examples of patients who did not have the capacity to consent to their procedure. We spoke with the dementia support team, led by a consultant psychiatrist and a lead nurse. They explained the support they gave to the ward staff, with regard to assessing patients, which demonstrated that support was available.
- There were no reported Deprivation of Liberty Safeguards (DoLS) applied to patients on the wards we visited. However the nurse on the support team had undertaken an audit of Deprivation of Liberty six weeks prior to our visit issues highlighted had been addressed.

Safeguarding

- There was a lead nurse for safeguarding. We saw posters with their picture, contact details and an outline of their role, around the hospital during our visit. However, when we spoke with staff, only some senior staff knew of the safeguarding lead. Most staff we spoke with were not aware of their presence.
- We spoke with staff about safeguarding concerns. Most were unsure how to escalate safeguarding concerns beyond their manager. This was despite the trust training matrix indicating that 95% of staff had received training. Therefore, the trust did not have robust safeguarding procedures in place.

Mandatory training

- We looked at staff mandatory training records. The trust had a target of 70% of staff in each directorate achieving compliance. The medical directorate had achieved almost all of their targets. However, the number of staff attending moving and handling training was below target on two wards. This meant that staff may not have received appropriate training on how to move patients safely.
- Senior nursing staff reported that it was a challenge to release staff to enable them to complete their training, even though most of it was done online.
- All grades of nursing staff reported some difficulties in accessing training due to work pressures, capacity and staffing levels.

Assessing and responding to patient risk

- The medical wards used an early warning tool called EWS. There were clear directions for escalation printed on the reverse of the observation charts, and staff spoken to were aware of the appropriate action to be taken if patients scored higher than expected, and may need intervention.
- We looked at completed charts and saw that staff had escalated patients' conditions correctly, and repeat observations were taken within the necessary time frames.
- There was a critical care, nurse-led outreach team, who were present on site 12 hours a day, seven days a week.

The team could be contacted by any member of staff, and their contact details were clearly displayed on all wards, as well as on the observation recording document. The ward staff reported that the outreach team were responsive to the patient's needs.

- Staff on several wards told us that, occasionally, when they escalated concerns regarding a deteriorating patient, to the medical team, particularly if the patient was an outlier, the response was not in line with the trust's procedures; occasionally, the appropriate medical team were not alerted, or the appropriate medical team did not attend to the patient promptly. For example, we found a patient who had had a stroke, of whom the stroke team were not aware.
- Patients were moved throughout the hospital, often out of hours, late at night. This was in an effort to get the most unwell patients into the ward that was most appropriate for their condition. However, there was no system in place to ensure that patients being moved, were assessed appropriately prior to moving, to ensure they were well enough.
- We saw two patients who had been identified as 'medically fit for discharge' (MFfD), who then deteriorated due to an existing condition, but their MFfD was not updated. Nursing staff told us this was not unusual, especially with older patients.

Nursing staffing

- Nursing numbers had been assessed for each ward. However, this was inflexible and staffing levels were not co-ordinated according to the patient's dependency or needs. Staffing cover was provided through the use of temporary agency staff, while new permanent staff were recruited into posts.
- All nursing staff told us that the trust had difficulty retaining staff, although we met many staff who had worked at the trust for over twenty years. One told us, "the managers don't listen. We lose really good staff because they can't cope with the pressure of always being short staffed." Another said, "we have lovely nurses here from Spain and Portugal, but they don't stay very long". Another told us, "there are so many junior staff from various recruitment campaigns, but there isn't enough seniors to support them properly". Doctors we spoke with made similar comments about the nursing staff. On Oxborough Ward, we observed that the nurse in charge had six patients to care for, as well as co-ordinating the ward and supporting junior nurses.
- Ideal and actual staffing numbers were displayed on every ward we visited. During our inspection, boards indicated that, in the main, the ideal numbers of staff were maintained on those days. On one ward, there was a shortfall of two nurses for the afternoon shift. The matron told us that she was trying to fill the shifts with temporary staff.
- We spoke with 15 senior nursing staff, nurse specialists and matrons across all directorates. Staff within the medical directorate said that while staffing levels had been reviewed on many ward areas, and the numbers of nurses had been increased, concerns still remained about the skill mix. They reported that there were concerns that the newly-appointed nurses required time for training, and that put pressure on the wards and on the delivery of care to patients. Ward staff reported that they were sometimes understaffed, and that vacancies were filled with agency staff wherever this was possible. One told us, "we're too busy to have time to care".
- Agency staff had a brief induction when they commenced their shift, which covered the ward layout, emergency procedures, and information to assist them with patients' care.
- Some senior nurses told us that they regularly worked extra hours for which they were not paid. They told us that they were not required to do so, but that they felt that they needed to, so as to ensure the safety of care on their wards.
- The trust had introduced a system whereby all the specialist nurses were expected to participate in the on-call and 'bed bleep' rota. This meant that they had to be available for hospital-wide troubleshooting; for example, with regard to bed management. They were concerned that this would take them away from their patients in their wards and clinics.
- We saw handovers on two wards. They were well run, and concise, relevant information was given about each patient. In the MAU, the MDT ward round did not commence until the nurse was present.

Medical staffing

- There were two consultants present on the MAU, 12 hours a day, seven days a week. On some medical wards, consultants undertook ward rounds daily; others took place up to three times per week.
- Due to regular, concurrent ward rounds on Stanhoe Ward, it was only possible for a nurse to attend one of the consultant ward rounds. On all wards, juniors were

not routinely accompanied by nursing staff on rounds, and communication regarding patients' status or change of treatment, relied on verbal transfers of information, or on nursing staff reading medical notes. It was not always clear that this had occurred.
- We observed MDT ward rounds, which were thorough, well organised, and well attended.
- All doctors told us that there were inadequate numbers of junior doctors on the wards, both during the day and out of hours. There was support from the specialist registrars on site, and consultants were contactable by telephone if they needed any support. One told us, "there are not enough doctors to complete the rota this month". Vacancies at all levels were filled with long-term locum staff.
- On the day of our inspection, we observed a consultant on duty who was not scheduled to work; they were also carrying a registrar bleep as well, to cover the shift on both consultant and trainee level. The doctor informed us that they were there for the patients, and being there was on their "goodwill" only. This demonstrated that there was an insufficient number of medical staff to support the service demand.
- Patients were seen rapidly in the MAU and on medical wards during the day. However, medical outliers were reviewed, but were not seen as a priority. One doctor told us that there was one medical outlier recently who had not been reviewed for five days.

Are medical care services effective?

Requires improvement

There were good arrangements for multidisciplinary working within the directorate. There was evidence of participation in national and local clinical audits. National audits demonstrated that outcomes were in line with those nationally. However, staff reported a lack of feedback and learning where improvements were identified.

Evidence-based care and treatment

- The medical department used a combination of National Institute for Health and Care Excellence (NICE) and Royal College guidelines to determine the treatment they provided. Local policies were written in line with this and other national guidelines, and were updated every two years, or if national guidance changed.
- There were specific care pathways for certain conditions, in order to standardise the care given. Examples included stroke, sepsis and acute coronary syndrome.
- The trust provided us with a list of all ongoing and completed audits during their past year. Most were in line with expectations.
- The majority of national and local audits were ongoing. Where completed audits identified areas for improvement in clinical effectiveness and outcomes for patients, there were action plans in place to address issues raised, and to improve the service.
- The stroke ward (West Raynham) had a bed 'ring fenced' to allow urgent admission for patients who required thrombolysis following stroke.

Pain relief

- Patients generally reported no problems with medicines; one person said that they asked for painkillers and after 30 minutes had to ask someone else. The same patient sought support from the inspection team to get staff to access to their medicines so that they could self-administer them.

Nutrition and hydration

- The trust had a 'Meal Mates' initiative, which was a nutrition campaign to ensure that patients who required support with their meals were assured of assistance. Staff from departments who did not have dependant patients, such as those in outpatients, were encouraged to assist wards that needed help supporting patients at meal times. There were mixed views from the staff as to whether it had been successful, as it relied on staff helping outside their department. We observed part of a meal service on two wards, and did not see any 'Meal Mates' present. However, we observed that assistance, given to patients who required support, was done sensitively, and at the patient's own pace.
- Stanhoe Ward had an alarm which was set to ring at the nurse's station 45 minutes before mealtimes. This was a reminder to the staff to ensure that patients were prepared for their meal.
- Protected meals times were in place on all wards we visited. We observed a lunch time meal on one of the medical wards. We saw all available staff went to assist

patients and helped them to move into a suitable position to eat. We observed one interaction where a nurse assisted a patient to eat. They engaged with the patient and asked them if they were ready for their next mouthful, however they did not sit next down with the patient.

- We observed a patient on Necton ward who was lying flat in bed and was receiving oxygen therapy. The patient's nurse call bell and bed table were not within their reach. Although there were nurses in and out of the bay, the patient did not manage to attract the attention of the nurse. When we went to assist the patient, they indicated to us they wanted a drink. We alerted the ward sister and the patient was then helped to sit upright and was assisted to have a drink.
- Relatives were encouraged and welcomed to help their relatives to meet their nutritional needs.
- On two wards, Necton and Pentney, we saw drinks out of the reach of more than nine patients.
- We observed patients on Oxborough Ward whose mouths and lips were very dry. Again, their drinks were often out of reach.

Patient outcomes

- Emergency readmissions were within expected parameters and the standardised readmission rates, comparing very favourably with national rates.
- We saw a summary of the clinical audits undertaken, including: the Myocardial Ischaemia National Audit Project (MINAP), Sentinel Stroke National Audit Programme (SSNAP), and the National Diabetes Inpatient Audit (NaDIA). Learning from these audits was still being identified and embedded.
- The department achieved level 'B' for their stroke services. Although the highest award is 'A', no trust has yet achieved this.
- The trust outcomes from the National Heart Failure audit compared favourably with other trusts, scoring particularly well in patients receiving specialist input and discharge planning.

Competent staff

- Nursing staff we spoke with had received an appraisal within the last year. Some reported having supervision, although this was sporadic. Most nursing staff told us that because there were so many more junior nurses then seniors, formal supervision did not happen routinely.
- Doctors reported appraisal and revalidation taking place according to General Medical Council guidelines.
- Although some wards in the directorate had completed 100% of appraisals, others were as low as 61%, making an overall rate for all staff of 70%. This was below the trust target. Some of the nursing staff reported that appraisals were done annually, but not referred to during the rest of the year; for example, with regards to personal development plans. Therefore, nurses did not value appraisal in the current format.
- Many of the medical staff working on the wards were locums.
- Despite the trust supporting further training more junior staff reported to us that the trust did not support further development, such as advanced life support courses for those not working in cardiac wards, or higher degrees. This was one of the reasons given by staff for the high turnover of nursing staff.

Multidisciplinary working

- There was clear evidence of multidisciplinary team (MDT) working on the ward. There was regular input from physiotherapists, occupational therapists and other allied health professionals, when required.
- There was evidence that the trust worked with external agencies, such as the local authority, when planning discharges for patients. However, senior staff reported that discharges were often delayed when dealing with some social services departments.
- All wards had white boards with patient details. The boards were situated where they were not in public view, thereby maintaining patient confidentiality. MDT meetings were held, both in ward areas, and around the patient.

Seven-day services

- There was a medical presence on the ward seven days a week. Consultants' ward rounds took place daily in some areas, such as in the MAU, and in other wards three times each week including weekends.
- Patients were seen by allied health professionals during week days. Nursing staff followed care plans at weekends to continue rehabilitation therapy with patients.
- Physiotherapists who gave respiratory support were on-call 24 hours.

Medical care (including older people's care)

- There was a daily ward round on the MAU, including at weekends. Medical patients on other wards would not be seen routinely, and would be seen by on-call physicians if they became unwell or if there were concerns about deterioration.

Are medical care services caring?

Good

Patients and the relatives we spoke with told us that staff were caring, kind and compassionate. They told us that medical staff were approachable. We observed medical and nursing staff treating patients sensitively and discreetly. The majority of patients we spoke with said that they had been involved in making decisions about their care and treatments, and that they had been given advice and information. Although some patients said they were not really involved in planning their care, they were happy to ask questions, and were confident in the treatment and support they were receiving.

Compassionate care

- In the April 2014 inpatients NHS Friends and Family Test results, nine ward areas scored below the trust average of 71.1%, for people who would recommend the hospital. Of the nine wards that scored below the trust average, six of these were medical wards. Medical wards displayed individual results, and the hospital results for patients' and relatives' information.
- The trust participated in patient-led assessments of the care environment (PLACE). The hospital scored slightly below average for food and privacy, dignity and well-being.
- Throughout our inspection, we witnessed patients being treated with compassion, dignity and respect. We saw that call bells were answered promptly on most wards. Patients and their relatives who we spoke with told us that staff were caring, kind and compassionate. People commented that nursing and care staff were "extremely kind and friendly" and that medical staff were "helpful and approachable". One told us, "having had care in the private sector, I am impressed with the care here. It surpasses that (which) I had in the private sector".
- We saw that comfort rounds (intentional rounding) were undertaken. Patients we spoke with told us that they did not have to wait long for assistance when they needed this. People said that staff were "always available" to assist. However, many patients commented on the low numbers of staff; one told us, "they are all so kind, but always really busy".
- We watched a number of ward rounds and consultations between doctors and patients. We saw that doctors introduced themselves appropriately, and that curtains were drawn to maintain patient dignity. Discussions between doctors, nurses and patients were carried out discreetly and sensitively, so as to maintain privacy.
- A relative told us that staff had been very accommodating and flexible with regards to visiting when their loved one was unwell. They told us, "they are really caring. I know they're busy, but nothing has been too much trouble for them to make sure my relative is comfortable".
- As the recovery area in the endoscopy unit was in one area, they arranged that for each session, day-only, same-sex patients would be treated. This ensured the dignity of their patients.

Patient understanding and involvement

- The majority of patients and relatives we spoke to stated that they felt involved in their care. They had been given the opportunity to speak with the consultant or the doctors looking after them. Most patients knew that they had a small team of nurses allocated to their care. One told us, "I have been kept informed of what is happening to me".
- Some patients told us that they had not been involved in discussions about their care. One said, "I am told to take my tablets, but I don't know what they're for". Some patients said that they were unaware of their planned care and treatment, or the arrangements for their discharge home. Some people made comments such as, "I am not sure what is happening", or "they said I'm going home, but I'm not sure when".

Emotional support

- Patients' emotional well-being, including anxiety and depression, were assessed on admission to each ward area, and appropriate referrals for specialist support were made, where required.
- Patients and their relatives we spoke with told us that they received emotional support from nursing and

medical staff. One relative, who was with a patient who was receiving end of life care told us, "they are wonderful, they don't just look after my relative, they look after me as well".
- Clinical nurse specialists were available to offer advice and support to patients and relatives about diagnosis and treatments.
- 0.4 of a whole time equivalent (WTE) clinical psychologist was available on the stroke ward (West Raynham), to support patients and relatives who were experiencing a life changing condition.
- A consultant psychiatrist was available three days a week to support people with dementia, delirium, or depression. The consultant was supported by a team of specialist nurses and carers.

Are medical care services responsive?

Requires improvement

The medical directorate services were not sufficiently responsive to the needs of all patients. However, there was access to specific support for people who had more complex needs, such as dementia and learning disabilities. Patients had access to the support services they needed, such as to therapists when they needed them.

Improvements were needed, both in managing the flow of patients between the MAU and other ward areas to reduce the number of transfers overnight, and to track patients through the hospital.

Service planning and delivery to meet the needs of local people

- Ambulatory patients referred by their GP were admitted via the ambulatory care department. This relieved pressure on the MAU and A&E. Patients were seen and treated rapidly, and referred onto other services if required.
- There were care bundles in place to ensure that treatment for the most common conditions, such as chest pain, reflected best practice and national guidelines.
- The MAU was very busy; the consultants and junior doctors told us that more junior doctors were needed to deal with the throughput of patients.
- The records of patients admitted from A&E to the MAU often did not arrive in a folder. It was reported to us that essential information, such as the results of crucial tests, was often missing.

Access and flow

- Bed occupancy was in line with the national average of 89% at the time of our inspection.
- The average length of stay for medicine was below the national average. This was facilitated by a 'virtual ward' system, in Norfolk, allowing supportive care to be delivered in the community.
- It was trust policy that bed moves were to be avoided after 9pm. However, staff reported that patients were often transferred around the hospital at night to allow for admissions from the MAU and A&E. This often had a negative impact on patient experience.
- A senior nurse reported to us that all overtime for the porters had been stopped recently. This had impacted greatly on patients' movement around the hospital, as delays were increased. The senior nurse told us that often senior managers were moving patients, which although it assisted with reducing delays, was not a good use of resources. We saw this occur on several occasions during our inspection.
- Daily board rounds were undertaken five days a week on most wards. Physiotherapists, occupational therapists (OTs), nursing staff, and junior doctors attended. Similar rounds took place on the MAU seven days a week, where a consultant was present.
- Estimated discharge dates were identified soon after a patient was admitted, and these were displayed on whiteboards, discussed at daily board rounds, and amended, as necessary.
- All wards in the medical directorate held multidisciplinary team meetings, which social workers, OTs and physiotherapists would attend. All staff we spoke with reported that there were effective arrangements and multidisciplinary working around discharge planning.
- On day one of our inspection, there were 17 medical outliers, on day two there were 21. It was reported to us that outliers had been reduced over the past months. Although most were reviewed regularly, staff reported to us that sometimes outliers were not seen as a priority, and it often took several telephone calls before they were seen.

Medical care (including older people's care)

- The consultant-to-consultant referral system was paper-based, and staff reported that it occasionally took up to six days for a referral team to visit, following the original paper request being completed.
- We visited the discharge lounge, and staff reported no concerns as to how the flow of patients for discharge to the lounge was managed.
- The move to a predominantly off-site pathology service, with incompletely implemented electronic test requesting, was leading to significant delays and problems getting results for patients who had moved location (such as moved to another ward) since the test was requested. One member of staff told us that there were risks to patient management, with significant backlogs of paper results to be seen by the relevant doctor, signed off and filed.

Meeting people's individual needs

- Support was available for patients with dementia and learning disabilities. A specialist dementia team was employed across the hospital. They were responsible for assessing and referring patients for appropriate treatment. 67% of staff in the medical directorate had received updated training in dementia awareness. This was within the trust's target.
- A learning disability hospital liaison nurse specialist was employed to provide support and advice to patients, relatives and staff. 65%% of staff had received training in learning disabilities, within the trust's target.
- The trust was working towards achieving a locally-agreed dementia CQUIN (Commissioning for Quality and Innovation – a payment reward scheme agreed by local commissioners aimed at encouraging innovation), for which it was required to ensure that patients were identified and assessed on admission with regards to dementia.
- Some leaflets and patient information were available in different languages on request, but were not routinely available on the ward.

Learning from complaints and concerns

- The majority of patients and relatives we spoke with during our visit told us that they did not have any complaints about their care and treatment. However, one patient was so disgruntled with their treatment that they decided to leave the hospital before the medical team deemed them fit for discharge.
- The complaints process was outlined in information leaflets, which were available on the ward areas. Some patients told us that they had been provided with copies of the leaflets. However, this was not consistent practice on all ward areas. One told us, "if I wasn't happy about something, I would ask to speak to the nurse in charge".
- Senior nursing staff told us that complaints about their areas were discussed at their meetings. We saw evidence of this in the sister's meeting minutes. They told us that providing feedback was difficult, as it was not possible for all staff to attend meetings. Nursing staff told us that they were not always made aware of complaints, and did not receive feedback about complaints or learning from these.
- Each ward had a 'communication folder'. These had been issued by the trust in June 2014, and contained details of serious incidents, complaints and actions, in an effort to make all staff aware; however, very few of the nursing staff were aware of these. We spoke with three members of staff, who had not seen the folders.
- At the listening event, a relative of a patient told us that they had written to the trust about a very serious complaint in November 2013, and did not receive a reply until February 2014. The person told us that the reply was very general and did not address the serious points they had raised.

Are medical care services well-led?

Requires improvement

The service requires improvement in leadership to ensure that services protect patients from avoidable harm. Departmental staff were aware of the risks of "lost" patients but there was a lack of action in addressing this and other issues. Staff across the directorate reported a lack of engagement with senior management at executive-level. Nursing staff reported good support and engagement with the director of nursing, but said that there was a lack of visibility of most other senior managers, including the chief executive. Some told us that they would not raise concerns to senior managers, as they would be concerned about reprisals. Staff did not feel 'listened to' or involved in making decisions, and there was little learning from incidents.

Vision and strategy for this service

- Staff we spoke with were not aware of the trust's vision and strategy, except for recruiting more staff. Staff at all

levels repeatedly expressed concerns about the changes to the executive board staff, and questioned the loyalty and commitment of the people in interim posts to the trust, concerning the vision and strategy.
- Some staff told us that their department had an 'executive buddy.' This was a board member who was allocated to every department, so that each member of staff could engage with a senior member of staff. Although some staff reported seeing their buddy regularly, most did not know who their buddy was, or if they did, had not seen them.
- Senior nursing staff we spoke with said that they did not feel involved in the decision-making processes within the trust. However, senior nurses said they felt confident in the director of nursing, whose post had just become substantive. They welcomed some stability.

Governance, risk management and quality measurement

- Wards used a quality dashboard and safety thermometer to measure their performance against key indicators. Where wards were consistently falling below the expected levels of performance, action was taken to improve performance by the nursing leaders and specialist nurses.
- There were regular governance meetings; however, most junior staff we spoke with were unsure of how governance worked to improve patients care. The meetings covered areas for concern, complaints, nursing indicators and plans for improvements in the safe delivery of patient care.
- Staff in the MAU reported that they received feedback and any learning points from incidents.
- Despite the trust supporting further training junior doctors reported that there was a lack of training opportunities provided by the trust.

Leadership of service

- All clinicians in senior leadership posts attended a clinical leadership and management course. Senior nursing and medical staff told us that there were good opportunities for leadership and development training. However, this did not extend to junior staff, who told us that there was no opportunity for further training in order to progress. A Band 6 nurse told us that they had been enrolled on a leadership course for that level of nurse.
- All grades of staff reported that the high level of changes within a short period of time had made it difficult to get to know everyone involved, and to manage all the new changes.
- Junior doctors told us that there were concerns about their experience and education within the trust; however, after a visit from the Deanery, who are responsible for commissioning doctors education, matters improved.
- We viewed the medical staffing plans for the service, to incorporate new trainees from August 2014, and found that there was to be a shortfall in medical staffing. We found no action plan in place to address this. Three doctors told us that they had raised concerns to management regarding medical staffing; however, they felt they were not listened to by senior management. One person told us, "the board keep changing; the risks are not dealt with".
- The junior doctors told us that they had appropriate support from middle-grade doctors, registrars and consultants.

Culture within the service

- Many of the staff told us that despite all the negativity surrounding the trust, they were proud to work there.
- Staff told us that they felt dedicated to doing the best for their patients, and valued their colleagues.
- Staff worked well together, and there was obvious respect, not only between the specialities, but across disciplines.
- Medical and nursing staff said that they felt supported by their immediate line managers. However, staff repeatedly told us that they did not feel like they had a voice with more senior managers.
- Many staff of all grades told us that they were fearful of reporting things; some cited a recent whistle-blower who had never returned to work. Staff felt that the culture was not open to reporting concerns.

Public and staff engagement

- The trust took part in the Friends and Family Test, but although the results were favourable, the overall response rates for the trust were poor, as low as 17%.
- The Patient Advice and Liaison Service (PALS) was situated in the main entrance, and was very visible. There was further information about the service displayed in public areas.
- Patients were not routinely provided with information about how to make a complaint.

Medical care (including older people's care)

Innovation, improvement and sustainability

- Staff within the directorate spoke positively about the service they provided for patients, despite all describing staff shortages.
- Nursing and therapists described the recruitment process as taking too long. Although they understood that recruiting someone into a post took time, they described that merely obtaining approval for filling a vacancy took "months".
- Although nursing staff valued the employment of staff from overseas, they questioned why recruitment was not taking place more locally, such as at recruitment fairs.
- On Stanhoe Ward, the ward manager had introduced and embedded a regular series of quality improvement activities, managed with senior nursing staff, and including regular feedback on the outcomes of each new initiative. This model, and other areas of good practice we saw, did not seem to have diffused into other areas within medicine.
- The medical service had recently opened an ambulatory care medical unit called AEC. This service was established by the consultant staff, and provides an effective service to the local people.
- The medical consultants on the MAU had also worked with the project management team within the trust to develop and implement care-specific 'care bundles.' These 16 care bundles follow national guideline requirements in an easy-to-use format. They are designed using a sticker format to go into patient records. The effectiveness of the care bundles in use had been audited, and results showed significant improvements in patient care, treatment and outcomes. We also saw that learning from these results had been implemented. This innovative work by the medical team was driving improvement in patient outcomes.

Surgery

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

Information about the service

The service was divided into three broad divisions: specialist surgery, general surgery, and theatres with two clinical divisional leads. The service consisted of eight areas: two elective surgery wards (Elm and Denver), one trauma and orthopaedic ward (Gayton), a short stay surgical unit (Leverington), a surgical assessment unit, a day surgery unit, and a pre-admission and elective admission unit.

Surgical service provision included orthopaedics, trauma care, ear, nose and throat (ENT), dermatology, maxillofacial, gynaecology, vascular, plastics, ophthalmology, orthodontics, interventional radiology, urology and gastroenterology services. There was also a dedicated endoscopy service within the day unit, inclusive of theatres and recovery facilities.

We visited all of the eight surgical units, including theatres. We spoke with 28 patients and relatives, 40 members of staff, including consultants, middle-grade and junior doctors, managers, junior and senior nurses, healthcare assistants, physiotherapists, a pharmacist and domestic staff. We examined 20 patient records, including medical notes, as part of this inspection.

Summary of findings

The services being delivered in surgery were safe, effective and caring but they were not responsive to the needs of patients. This was due to the practice of bringing day case patients in the day prior to operation or undertaking these patients operations at the end of the list which impacted upon the time they remained in hospital. This also had an impact on the overall capacity of the hospital to treat patients in a timely manner and led to a high number of cancellations of operations. The medical leadership team within the surgical directorate was disparate which impacted on patient care. We found issues with the privacy and dignity of patients attending for breast care.

Whilst we found minor issues with the documentation of the cleanliness of equipment in general the ward environment was clean. People spoke positively about the staff. Staff treated people with kindness, dignity, respect, compassion and empathy while providing care and treatment.

The trust had a clear vision and credible strategy for each surgical unit. The leadership and culture within the organisation reflected its vision and values, and encouraged openness and transparency. The trust engaged with patients, families, visitors and staff, seeking and acting on their feedback to improve the quality of the service. The service took adequate steps to learn continually and improve, to support safe

Surgery

innovation, and to ensure future sustainability and quality of care. The leadership in the service particularly encouraged staff to be innovative, caring and co-operative.

Are surgery services safe?

Good

The services being delivered in surgery were safe. There were reliable systems, processes and practices in place to keep patients safeguarded from abuse. Compliance with mandatory training was undertaken, and patients were care for by competent staff. Staffing levels were sufficient to ensure safe and effective care. However we found inconsistent use of the 'I am clean' green stickers on equipment across the service. This made it difficult for staff to determine whether equipment was clean or not. Whilst we observed nurses checking the controlled drugs appropriately, we found that on most wards, there were three controlled drug books.

Incidents

- The surgery service had reported two 'never events' within the past year. 'Never events' are serious, largely preventable patient safety incidents that should not occur if the available, preventable measures have been implemented. Both 'never events' were investigated thoroughly, and lessons to be learnt were identified and being implemented.
- The service reported one of the 'never events', after a discussion with a patient post-operatively, who believed that the wrong area had been excised during an exploration and excision procedure. An investigation determined that it was unlikely that the wrong site of surgery had occurred, and consequently, this was not a true 'never event'. However, there was evidence of learning from this incident. We spoke with senior managers and doctors, who were able to tell us about this incident and described practices that had been implemented to prevent re-occurrence.
- The service had reported 16 serious incidents between May 2013 and May 2014. These incidents predominantly involved pressure ulcers, slips, trips and falls, and drug errors.
- We were assured that staff were reporting incidents appropriately. There was a robust system in place for reporting adverse incidents, called the 'Datix' system. Staff we spoke with across all units were familiar about when they should report an incident and how it should be done. Staff gave us examples of incidents they had reported.

- There was evidence that staff were learning from incidents, and that care was subsequently being improved. One serious incident related to multiple drug errors being made, and we found that the service had taken appropriate action. New medicine practices had since been implemented. The practice development nurse offered support for staff, and nurses wore red tabards during medicine rounds, which indicated that they should not be disturbed. We were assured that senior management were taking appropriate action following serious incidents.
- Incidents and learning were regularly fed back to staff. In theatres, we saw details of recent incidents on the staff notice board.
- There was a monthly, trust-wide mortality meeting which lead surgical representatives attended.
- The World Health Organization (WHO) safety checklists were being used by staff in the operating theatre to confirm patient identity and the scheduled operation. There was evidence that the unit had worked to modify and adapt it to local circumstances, as proposed by WHO. A rolling audit of the WHO checklist took place in January 2014, and identified that the checklist was undertaken appropriately on 88% of occasions. This represented a decline in performance when compared to previous audits. There was clear dissemination of results to all theatre staff and subsequent improvement. We observed the WHO checklist being completed fully during our inspection.

Safety thermometer

- The trust displayed up-to-date safety thermometer information at the entrance to each ward. This method of data collection determines levels of harm-free care. This included information about all new harms, such as falls with harm, new venous thromboembolisms (VTE), catheter use with urinary tract infections, and new pressure ulcers. There were also easy-to-read explanations of the nursing metrics on display.
- Overall, the information showed that the trust consistently reduced the percentage of patients who experienced harm. There were some wards which reflected excellent levels of harm-free care. The surgical assessment unit demonstrated consistent harm-free care; for the past four months they had a safety thermometer score of 100. Denver Ward's safety thermometer readings indicated that pressure ulcers were high in comparison to other surgical wards, and that there had been some recent incidences of VTEs. However, a number of measures had since been implemented to improve these results.

Cleanliness, infection control and hygiene

- Both staff and external contractors used cleaning schedules to ensure that all areas were regularly cleaned.
- Staff were compliant with infection control training. On Gayton and Elm Wards 100% of staff had completed infection control training in the past year.
- All areas and equipment appeared to be visibly clean. Nursing staff practiced good hand hygiene, used gloves and aprons when required, wore uniforms above the elbows, and adhered to trust infection control policies. The provider may like to note that we observed some doctors not decontaminating their hands prior to attending to a new patient.
- There was hand gel available throughout the wards and assessment units. A prompting system was found at every door entrance, which reminded everybody to decontaminate their hands prior to entry. All units undertook various infection control audits at local level. Wards openly displayed these findings on boards at entrances. Generally, audits reflected good infection control practices.
- We found inconsistent use of the 'I am clean' green stickers on equipment across the service. This made it difficult for staff to determine whether equipment was clean or not.
- Patients had limited access to isolation facilities. Staff knew the procedure to follow for patients who required isolation.

Environment and equipment

- Fire evacuation information was displayed and visible to visitors. We found that the ward environments were bright, clean and organised.
- Records for adult resuscitation equipment demonstrated that staff checked equipment regularly. Resuscitation equipment was in good working order, and emergency medicines in date. However, we found that there was only one adult resuscitation station for Denver and Elm Wards. This meant that if two people required this resuscitation equipment, then there would

be a significant delay in appropriate resuscitation for one patient. We discussed this with a senior manager and were assured that appropriate action would be taken.
- The service commissioned regular safety checks for equipment. We found that equipment was in good working order and had been safety checked.

Medicines

- Staff were compliant with medicines management training. In the past year, 97.30% of staff on Elm Ward had received medicine training. Similar figures were found from Denver (100%) and Gayton Wards (97.73%) training records.
- Medicines, including controlled drugs, were stored securely. Records showed that staff checked fridge temperatures regularly. However, we found that some medicine storage rooms were not temperature controlled, and the temperatures within the room were not routinely checked. These rooms were very warm. We were therefore not assured that all medicine was being stored appropriately and as per manufacturer's recommendations. We discussed this with ward leaders, and were assured that appropriate action would be taken to monitor temperatures.
- We observed staff administer medicines safely. Records demonstrated that medicine was prescribed and administered correctly. There was also an effective system in place for the safe disposal of medicines.
- The service was monitoring the management of controlled drugs, and entries in the controlled drug books were consistently signed by two staff. Whilst we observed nurses checking the controlled drugs appropriately, we found that on most wards, there were three controlled drug books. This made the controlled drug checking process complicated and lengthy. Nurses reported that this was a concern.

Records

- Record keeping was of a high standard, contemporaneous, and in line with national record keeping guidance.
- Staff had recently received healthcare record keeping and information governance training. Records confirmed that training levels were good across the department.
- Patient's medical records were stored securely behind nursing desks. Nursing notes, such as patient drug charts and risk assessments, were kept by bedsides in folders. However, in some areas, these patient folders were tucked in to the end of patient's beds, between the mattress and the bedframe. This may increase the risk of cross-infection.
- Regular record keeping audits occurred. In April 2014, an audit of theatre documentation identified poor record keeping. Out of 140 patient records, only 13 had complete documentation. Following this, a robust action plan was implemented, including addressing staff who practiced poor record keeping, and reviewing individual record keeping at appraisals. On the day of our visit we found that documentation in theatres was completed appropriately.
- Patients had appropriate risk assessments, and care was tailored accordingly. Adult inpatients had a detailed nursing risk assessment booklet in their care records. There were numerous risk assessments, including disability, safeguarding, moving and handling, bed rails and nutritional.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff provided appropriate information to patients about procedures. Patients who were able to, had provided written consent to procedures. There were supporting patient information leaflets for consent, which were given to patients pre-operatively.
- For patients who did not have capacity to consent to their procedure, staff applied the principles of the Mental Capacity Act 2005.
- Compliance for training on consent were below the level that the trust expected. Elm Ward training figures confirmed that 59.46% of staff had received consent training. However, staff we spoke with demonstrated good knowledge and the principles of obtaining valid consent, and confirmed that this was a new element to their training profiles.
- Staff demonstrated good knowledge about Deprivation of Liberty Safeguards (DoLS), and had access to relevant information. We observed DoLs posters in the staff room, which incorporated key contact numbers for DoLs advice.

Safeguarding

- Staff were knowledgeable about their role in safeguarding, and confirmed that they had received

safeguarding training in the past year. Staff were able to describe the different types of abuse, and correctly tell us what they would do if they thought someone was being abused.
- Information about the trust's safeguarding arrangements, including a safeguarding policy and key contact and referral details, were readily available to staff on the unit.

Mandatory training
- Staff said that they were up to date with their training, and felt equipped to provide safe care.
- Records confirmed that staff compliance with mandatory training was around or above the trust's set target of 70% across all surgical units.
- Records confirmed that most staff had received both adult and children's safeguarding training.

Management of deteriorating patients
- We observed that there was suitable equipment, systems and processes in place, to ensure that patients were assessed and monitored appropriately.
- The Early Warning Scoring System (EWS) was used throughout the surgery service. The EWS is an agreed set of measurable patient signs and symptoms, which assist in the recognition of sick and deteriorating patients. We observed that patient EWS charts were completed appropriately. Staff knew what various EWS scores meant, and when they should escalate a concern. There were regular audits of the use of EWS.

Nursing staffing
- Although staff appeared busy, we observed that there were a sufficient number of trained nursing and support staff, with appropriate skills, on duty to ensure safe and effective care. Staff told us that they received their entitled breaks.
- Planned and actual nursing numbers were displayed openly on the wards.
- Staff told us that they felt well supported. One nurse said that they "would not want to work anywhere else". Nurses told us that staffing numbers had improved and one nurse said, "we are better staffed now than before".
- Staff said they reported through the trust incident reporting system, when the wards were understaffed. We saw examples of this. There were nursing vacancies in numerous areas, and active recruitment was ongoing to fill these posts.
- A bank staffing system was used when there were shift vacancies. Senior managers told us that they try to use the same bank staff were possible, usually as the ward staff to ensure staff continuity. Staff said that on occasions, agency staff filled vacancies when bank staff were unavailable. All agency staff were inducted locally on arrival for their shift.
- Handovers between staff were effective. Delegation was clear, and communication skills were good.

Surgical staffing
- There were a sufficient number of junior and middle-grade doctors on duty to ensure safe and effective care. There was a consultant surgeon on-call, which ensured that there was consultant availability 24 hours a day.
- Doctors spoke positively about working for the trust. One doctor told us that they were "overall very happy here". Another said that they "feel really supported".

Major incident awareness and training
- Surgical services followed the trust's major incident and escalation policy. Major incident information was available for all staff to access on the trust's intranet. We viewed the trust's training matrix to determine how many staff within the service were trained in major incidents, and found that this was listed as mandatory training by the trust. We were unable to establish how many staff in the service had been trained in major incidents.

Are surgery services effective?

Good

Staff assessed people's needs and delivered care and treatment in line with current legislation, standards, and national or internationally recognised evidence-based guidance. The trust made sure that equipment and facilities enabled the effective delivery of care and treatment. The trust supported and enabled multidisciplinary working within and between services across the organisation, as well as with external organisations. Surgery services were effective however the number of non-elective readmission rates was higher than the England average.

Surgery

Evidence-based care and treatment

- Elective services used a combination of National Institute for Health and Care Excellence (NICE) and Royal College of Surgeons (RCS) guidance, to determine provision of treatment. These included NICE guidelines on upper gastrointestinal bleeding and breast cancer.
- A general surgery audit had recently been completed. The aim of this audit was to review whether patients on the wards had a clearly identifiable consultant allocated to them, and if this was consistent throughout their documentation. Results showed that improvements were required. The audit action plan stated that on admission, junior doctors needed to document the lead consultant on patient boards, and in patient records. There was evidence that this new practice was disseminated among staff, and that this practice had been implemented.
- Records confirmed that varying surgery-related audits occurred at local level. There was evidence that learning from audits had improved practice.

Pain relief

- Staff assessed patients pre-operatively for post-operative pain relief. For elective patients, this process happened during the pre-assessment clinic. Supporting patient information leaflets on pain relief after surgery were also given to patients before their procedure. These leaflets were detailed, and covered epidural and anaesthetic information.
- Patients told us that pain was regularly assessed and that "nurses are quick with pain relief". One patient who had recently had surgery told us, "they are ever so quick to bring me my tablets if my knee starts to hurt". Nurses frequently documented patient pain scores, and medication charts confirmed that pain relief was given as prescribed.
- There was a dedicated pain team within the trust. Staff knew how to contact them for advice and patient treatment when required. In general theatres, a pain team nurse attended the recovery area daily to discuss pain management with patients that were identified at pre-assessment as high risk, such as those with chronic pain. A pain team nurse also visited Denver Ward daily, to review patients with epidural anaesthesia.
- Protocols for patient controlled analgesia (PCA) and epidurals were readily available to staff, and were in line with national guidance. Patients with epidural anaesthesia were only admitted to Denver Ward. This ensured that nurses became competent and effective in delivering post-operative epidural care.

Nutrition and hydration

- On the wards and assessment areas, patients had jugs of water by their bedside. We observed regular tea rounds, where by patients were offered a choice of hot beverage. Patients told us that "food has been very good here" and "food was excellent".
- Patients had access to special diets which met their individual needs. This included halal and gluten-free diets. Staff confirmed that snack boxes were available for patients 24 hours a day, if needed.
- Diabetic patients received care in line with trust protocols, and there was evidence that patients were referred to dieticians if their Malnutrition Universal Screen Tool (MUST) score was considered high risk.

Patient outcomes

- CQC's Intelligent Monitoring (which looks at a wide range of data, including patient and staff surveys and hospital performance information) did not identify any mortality outliers in surgery.
- In 2012/13, the trust participated in numerous national surgery-related clinical audits. This included the Lung Cancer Audit (2012), Hip Fracture Audit (2013) and Bowel Cancer Audit (2013). Participation in national audits demonstrates the service's commitment to improving patient care.
- Lung cancer audit results confirmed that the trust was performing better than the England average. This was in relation to discussion of cases at multidisciplinary team (MDT) meetings, and the percentage of patients receiving a CT scan before bronchoscopy.
- The trust surgical site infection (SSI) rate data, from July to September 2013, published by Public Health England, showed that people were at a lower risk of SSIs compared to other hospitals.
- Non-elective readmission rates were higher than the England average, with particular regard to general, trauma and orthopaedic surgery. The service also demonstrated that it was performing worse than average on improved groin hernia and varicose vein.

Surgery

Competent staff

- Staff said they received an annual appraisal. The trust's training and development dashboard confirmed that in February 2014, 91.23% of surgical staff had received an appraisal.
- There was a trust policy for the medical revalidation process. Doctors confirmed that they were supported with revalidation. However, the provider may like to note that some staff shared concerns that junior doctors often missed scheduled teaching due to work-related demands. Senior doctors said they felt that there was a need for more teaching of senior and middle-grade doctors.
- There were a variety of competency frameworks in each area that were relevant to the unit that staff were working in. In theatres, there was a competency framework for all specialities, and an induction programme.
- The practice development nurse and pain team provided enhanced clinical skills training for nurses and health care support workers. This included venepuncture and catheterisation skills. Staff and records confirmed good attendance.

Multidisciplinary working

- Members of the multidisciplinary team (MDT) were involved in ward rounds. On Denver Ward, there was a recently introduced MDT round, which occurred in the morning and involved physiotherapists, discharge liaison nurses, a social worker and an occupational therapist.
- Occupational therapists and physiotherapists worked on the ward areas predominantly, but also had input in pre-assessment care. We observed that staff had a good rapport with other members of the MDT, and that there was effective communication between them. On Elm Ward, we observed a member of staff providing care to patients in the morning, and following this they gave a structured handover to the nurse in charge. This included key updates, such as discharge suitability.
- Minutes from a recent senior nurse meeting confirmed that varying members of the MDT were invited to speak as guests, including representatives from pharmacy and estates. This improved MDT communication and role clarity.

Seven-day services

- There were daily consultant ward rounds, and a consultant surgeon was on-call 24 hours per day, seven days a week. On the wards at night, there was a specialist registrar and junior doctor cover. Junior doctors told us "night experience is excellent", and that they "feel well supported".
- Theatre staff told us that staff work six days a week to cover the fractured neck of femur pathway; however, there are systems in place to work seven days as required. In general theatres, four members of theatre staff were on duty for emergency care during the night time, every day.
- There were arrangements in place for access to radiology, other diagnostic services, and pharmacy services, out of hours.

Are surgery services caring?

Good

People spoke positively about the staff. Staff treated people with kindness, dignity, respect, compassion and empathy while providing care and treatment. The trust involved people who used the service, and those close to them, as 'partners' in their care and treatment. Patients and their families were positive about the staff team. They said they were attentive and caring.

Staff supported people to make informed decisions. There was a wide range of information available for visitors. Staff provided patients, and those close to them, with the support they needed to cope emotionally with their care and treatment.

Compassionate care

- We observed that staff treated people in a warm and caring way. Patients consistently spoke positively about staff. One patient said "care has been excellent and I couldn't have asked for more". Another patient said "staff are fantastic and go out of their way to help". Patient's dignity was respected. During a ward round, doctors introduced themselves to patients, and drew curtains to maintain patient dignity.
- Between April 2013 and April 2014, the trust collated results from each department's Friends and Family Test (FFT.) We reviewed data from Denver, Elm, Gayton and Leverington Wards, and found that generally, the results were good. During May 2014, the results showed that 35 out of 47 patients on Elm Ward said that they were "extremely likely" to recommend the service to friends

or family, and six said they were "likely". There were no negative results. Comments included "all grades of staff were very helpful and friendly" and "amazing service thank you".

Patient understanding and involvement

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Emotional support

- Staff assessed emotional needs and provided appropriate emotional support to patients. Emotional well-being was assessed pre-operatively. There were hip, knee and hernia surgery questionnaires, all which assessed anxiety and depression.

Are surgery services responsive?

Inadequate

The surgery service was not responsive because the trust did not plan and deliver its services to meet the needs of different people. Patient access to surgery was limited by hospital capacity; this resulted in last-minute changes to the theatre lists and patient's operations being cancelled on the day. The trust did not take adequate steps to ensure that people accessed its services in a timely way. Patient flow was disorganised, at times resulting in poor patient experience of the service.

Staff took account of people's needs and wishes throughout their care and treatment, including at referral, admission, discharge, and at transitions. The trust routinely listened to and learned from people's concerns and complaints, to improve the quality of care.

Service planning and delivery to meet the needs of local people

- Cancellation rates were much higher than average. During our visit, staff told us that five out of 19 elective patient's operations were cancelled that morning, due to lack of bed capacity. Staff confirmed that this was a regular occurrence.
- The number of patients, whose operations were cancelled and were not treated within 28 days, was consistently higher than the expected range. Between April 2013 and April 2014, 66 patients were not treated within 28 days following cancellation. Senior managers explained that this was largely elective surgery being cancelled, and that this was due to medical and emergency surgical outliers.
- During our visit, we identified five medical patients on Leverington Ward on one day. On another unit, staff confirmed that medical outliers were an issue. One staff member told us that medical outliers "do not get the best and specialist care they deserve" because they were on a surgical ward. This concern was reflected by staff throughout the wards and assessment units. We were not assured that service planning and delivery were arranged to meet the needs of local people.
- Staff shared concerns about breast care. They told us that the room used for breast care triple assessment is too small to have the correct amount of people in to give cancer diagnosis sensitively, and that before this, these patients are in the general ultrasound waiting area, and have to cross the corridor for scans before going back to the small room for diagnosis. This meant that the division had not planned its service to ensure patient's dignity and sensitivity.
- The service had business continuity plans written and in place; however, these were currently not fit for purpose. Whilst protocols were in place for deferring elective activity to prioritise unscheduled emergency procedures, many elective cases had been cancelled due to capacity issues within the hospital. Therefore, the business continuity plans did not support the safe

delivery of elective surgery. We spoke with three doctors, who confirmed that their business continuity around elective surgery was poor, and the non-delivery of elective surgery affected the patients.
- Bowel cancer audit results demonstrated good outcomes for patients. The trust's case ascertainment rate at 99% was significantly higher than the England average of 86%. The hip fracture audit results reflected either better than average results or similar, when compared to the England average.

Access and flow

- The trust referral to treatment time (RTT) was above the national average. This meant that patients waiting for referral for medical treatment had shorter waiting times.
- In seven out of 11 specialities, the referral to treatment time (RTT), which is a maximum target period of 18 weeks, was worse than average. Operational standards are that 90% of admitted patients and 92% of incomplete pathways should start consultant-led treatment within 18 weeks of referral. These standards were not being met.
- Most recently, general surgery (85.5%), trauma and orthopaedics (69%), ear, nose and throat (84.2%), urology (87.9%), oral surgery (89.3%), and plastic surgery (78.4%), were not meeting the RTT standard on admitted adjusted. (Admitted adjusted is a term used that describes RTT data that has been adjusted to take into account delays introduced because patients may turn down offers of admission made with reasonable notice.)
- The day surgery unit was organised well. Patient flow was smooth with minimal waiting.
- For elective surgery, there was a pre-admission unit. Patients were usually admitted here on the day of their surgery. Staff told us that this was an effective system. Patients who required emergency surgical care were admitted via the emergency department, or the outpatient department. The service had a low day of procedure rate for colorectal surgery when compared to other specialities. We discussed this with senior nurses, and were told that patients come in, the day before surgery, for bowel preparation as per consultant requests. There was no other rational for this process. Staff confirmed that colonoscopies were prepared on the day. This was therefore not an effective process, because patients were unnecessarily attending hospital on two occasions as opposed to one.
- There were several day case rates below the expected standard. This means that patients were not being treated as day cases. This predominantly involved breast, vascular and ear, nose and throat (ENT) surgery. Breast surgeons told us that they often complete day cases at the end of general lists, and that this explains this low rate and impacts on the bed availability at the hospital.
- On the day of our visit, there were surgical patients being nursed on inappropriate wards. This did not meet their needs. One patient was being nursed on a medical ward, and told us that they had not been seen by the surgical team for six days, despite nurses requesting surgical review. We spoke with the ward lead about this, and were assured that this person would been seen promptly.
- Average length of stay was lower than the England average for elective and non-elective surgery. One patient shared concerns that they felt they were being discharged too early. Staff told us that because of the high rate of elective admissions often this meant that some patients were discharged earlier than expected. Staff were, however, clear that patients were not sent home unless it was considered safe.
- Discharge planning commenced on admission, or before for elective patients. Staff told us that there was a discharge planning team which supported people with complex needs. However, in other areas, staff told us that "flow out of the hospital was a major problem" and that this was because there was often a delay in completing discharge letters. One patient told us, "they are making me go home too early". Another said that they were not kept informed about their discharge suitability.

Meeting people's individual needs

- Patients who required translation services were identified during pre-admission clinics. Nurses then organised translation services in good time for admission.
- There was a translation service available 24 hours a day, to support patients and relatives with limited English proficiency. Staff could access this service via the Patient Advice and Liaison Service, or through the trust telephone switchboard.

- There were allocated staff 'champions' for learning disabilities and dementia on each unit. All of these 'champions' had completed appropriate training, and provided updates on their subjects to their teams.
- In the day surgery unit, there were specific patient pathways for children and adolescents. Child pathways included additional aspects of care, such as capturing details of the child's school, and health visitor, and confirmation as to whether the children's day surgery book had been given.
- On the surgical admission unit, patients commenced treatment, such as diabetic protocols, in accordance with pre-admission decisions and trust policy.
- Staff we spoke with had received training in learning disability issues, and were aware of key contacts in the hospital that they could access for support.
  Pre-admission staff told us that if someone has learning difficulties or a disability, such as being deaf, then care would be tailored to people's needs and arranged for the day of surgery.

Learning from complaints and concerns

- The trust had a visible complaints process. There were posters displaying details of how to make a complaint, and comment boxes in ward areas. Boards in public areas displayed patient feedback from inpatient surveys, as well as data on complaints. Managers said that they reviewed these comments regularly, and always acted to improve the service where possible.
- Patients were encouraged to give service feedback. On admission, patients were given questionnaires to complete upon discharge. Staff described the importance of dealing with people's concerns straight away, before they developed into more significant complaints. They explained how they would escalate concerns to senior staff, who would try to resolve the issue.
- The service demonstrated that it learned from complaints and concerns. The day surgery unit had recently received a complaint that there was insufficient patient literature available. Subsequently, the service started to take action, and had developed further patient information leaflets. This included a concise information booklet for day surgery patients, with details about anaesthesia and what will happen on the day.

Are surgery services well-led?

Requires improvement

The leadership of the service required improvement. The communication between the divisional leads required improvement to ensure that both elective and emergency patients received a good service. The non-attendance of managers at the regular bed meetings impacted upon the care surgical patients received leading to delays and cancellations. However communication amongst teams was good and a number of initiatives were in place to ensure that individual teams were supported and informed of changes. Staff had a good understanding of the vision and strategy for the department. Staff morale was good despite communication difficulties with clinical leads

Vision and strategy for this service

- Each unit within surgery had a clear service specification, which outlined service provision, aims and objectives. Staff we spoke with were aware of these documents.
- Staff told us that they had recently received copies of the trust's new values and behaviours, within their payslips. Staff confirmed that they knew who the chief executive of the trust was, and that they saw him regularly walk around the service and talk to staff.
- Staff had a clear understanding of the trust's vision, values and objectives, which were displayed throughout the service.

Governance, risk management and quality measurement

- Incidents, complaints and audits were analysed and reported, through the governance team, to the board.
- Nursing managers disseminated information about incidents, risks and complaints to the staff in their area. On the surgical assessment unit, the ward sister wrote comments on the staff board, such as complaints received and actions needed. Elm Ward had a monthly 'Elm News' report, which included feedback from local audits and practice development information, such as how to improve handovers between staff.
- Each unit had a risk register, which was updated quarterly and reflected current risk; plans of action were tailored to each risk, with regular review dates.

Surgery

- Staff were familiar with, and had access to, the trust's risk reporting and risk management system. This included details of risk management policies.
- There were a number of unit meetings that occurred monthly. In addition, regular senior nurse meetings took place with a representative from each unit. Meetings were minuted, and an action monitoring record was developed after each meeting, which highlighted key areas that required action, with clear deadlines. Previous actions set were also reviewed.
- Theatre services met monthly to discuss standards and quality. General surgery had monthly governance meetings, and there was evidence that the services risk register, incidents, complaints, audits and mortality were reviewed. Surgical leads also attended monthly trust-wide quality meetings.

Leadership of service

- Unit managers and nursing leads were dedicated, enthusiastic and inspiring. The managers of each unit demonstrated clear leadership principles and the trust values. Staff spoke highly of their seniors. They said that they felt respected, valued and well-supported by managers. One staff member told us "the support is why I want to stay working here".
- Divisional managers from the non-elective division, and nurses from each ward, attended trust bed meetings up to three or four times a day, to assess outliers and the capacity for elective admissions. However, staff shared concerns that divisional managers from the elective division did not attend these meetings regularly. Managers told us that it was important for all leads to attend these meetings, as attendance from a multitude of staff was leading to delivery improvements. Staff told us that this was because they understood the system better. One divisional manager told us that they did not know what the other divisions' action plan was to improve current bed capacity issues. There was a lack of communication between the two divisions, which was concerning, given the interrelated issues.

Culture within the service

- There was a positive ethos and clear mutual respect between colleagues. Staff throughout the service said that they were passionate about their job, and felt respected and supported by peers.
- Staff were very busy, but the general atmosphere was positive, and people were cheerful.
- Staff were very open and honest with inspectors. They explained what worked well, and what did not work as well. Staff said they would raise concerns with managers if necessary, in line with the trust's whistle-blowing policy, and they felt that they would be listened to. Staff gave examples of when they had done this, and how managers had taken appropriate action.

Public and staff engagement

- Across the surgical units there were consistent mechanisms in place which encouraged public feedback. This included trust-wide comment cards called 'iWantGreatCare'. Staff actively encouraged patient feedback.
- There were 'how are we doing' boards on each ward entrance, which detailed clinical indicators and performance. These were visible to patients and visitors.
- Staff from some areas told us that they were encouraged to engage with the service. Minutes from a recent senior nurse meeting confirmed that staff were recently involved in developing the trust's new manual handling paperwork. However, in other areas, where ward meetings did not occur, and where newsletters were used instead, it was less clear how staff could engage with the service.

Innovation, improvement and sustainability

- The service had introduced 'care rounds' into wards and assessment areas. Care rounds were two hourly checks for patients by registered nurses. They consisted of a checklist, which assessed people's pain levels, positioning and toilet needs. We observed these rounds being undertaken.
- The tissue viability lead encouraged staff to improve pressure area care for patients through a number of incentives. Pressure area incidences were visible on every ward, regular pressure ulcer meetings occurred, which included root cause analysis and lessons learnt identified, and - when a unit reached 100 days without a pressure ulcer - every member of staff received a new pink fob watch and a unit certificate. We observed patient education leaflets on pressure ulcers, and detailed staff education booklets, with pictures grading pressure ulcers for educational purposes.
- There were yellow communication folders on most units. Staff told us that they had recently been introduced. Folders consisted of senior nurses meeting minutes, ward meeting minutes and ward newsletters, clinical indicators which flagged success and shortfalls,

and recent results of the unit's Friends and Family Test. Whilst on some wards, some staff were not familiar with these folders, on most areas, these folders had been implemented effectively.

- On each ward, every patient board had a red, amber, green magnet system. For example, if a red magnet was next to a patient's name this meant that this patient was at high risk of falls. This alerted all members of the MDT. Staff told us that this was an effective system.
- Staff in theatres were piloting a project, whereby they were completing five joint replacements a day, as opposed to four. They had estimated that this could save the trust £60,000 per annum.

Critical care

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

Information about the service

The critical care service at the Queen Elizabeth Hospital consisted of the critical care unit (CCU) and the critical care outreach team. CCU provided care to both level two and three patients needing advanced and/or basic organ support. Level two patients require support of one organ, and level three patients require support of two or more organs and/or are ventilated. At times, this service provision included paediatric critical care. The critical care outreach team were based in CCU, and assisted with the management of critically ill patients on wards across the hospital.

In CCU, there were 11 beds available to support level two and three patients, a further two beds were allocated to elective surgery patients who were considered high risk by the surgical teams, and three coronary care beds were reserved for cardiac patients. Whilst the critical care nurses provided care to coronary care patients, this aspect of critical care was led by the medical team. The CCU service provided a variety of organ support, such as invasive and non-invasive ventilation, cardiac support and monitoring, and hemofiltration for renal support and sepsis.

We visited CCU, and spoke with six patients and one carer, six nurses, two managers, the lead consultant and four doctors. We observed patient care, examined three sets of patient records, and spoke with the critical care outreach team.

Summary of findings

Patients and their families said that staff were attentive and caring. Staff treated people with kindness, dignity, respect, compassion and empathy, while providing good care and evidence-based treatment. Staff worked well as a team, felt supported by their line managers, and were highly motivated to provide patients with the best care possible.

The service had a clear vision and credible strategy to deliver high-quality care and promote good outcomes. The service was actively involved in national and local research and audit projects, and demonstrated innovation through involvement in equipment design. The trust engaged with patients and visitors, and acted on their feedback.

The trust's track record on safety was good. There were reliable systems, processes and practices in place to keep people safe and safeguarded from abuse. The trust learned when things went wrong, and improved safety standards as a result. We were concerned that there were no side room facilities for coronary care patients; however, we were reassured that this was already on the service risk register, and that senior managers were taking appropriate action by looking at ways to resolve this issue.

Some outcomes for people using the service were good compared to other services. There were periods in the past year where bed occupancy levels were above the

Critical care

England average. These capacity issues meant that patients were not always cared for in the most appropriate setting for their needs, and elective surgery got cancelled.

Are critical care services safe?

Good

The trust assessed and monitored safety in real-time, and reacted to changes in risk levels in the service or for individuals. The trust anticipated potential risks to the service, and developed plans in advance to manage these risks.

The trust's track record on safety was generally good. However, we found that there were gaps in checking records for paediatric equipment. This was inclusive of resuscitation equipment. Staff were not clear whether CCU or the paediatric department were responsible for checks. We bought this to the manager's attention and were assured that this issue would be resolved promptly.

There was a lack of side rooms in CCU. This meant that patients who required isolated nursing care did not always get nursed in a side room. This increased the risk of infection cross-contamination. There were also no side room facilities for coronary care patients. Records and managers confirmed that these issues were high on the service risk agenda, and they could demonstrate that appropriate action was being taken in an attempt to resolve the concerns.

The trust learned when things went wrong and improved safety standards as a result. There were reliable systems, processes and practices in place to keep people safe and safeguarded from abuse.

Incidents

- The service had reported one serious incident between May 2013 and May 2014. This involved a patient inadvertently being given an overdose of a potent drug, which caused temporary harm to them. The service undertook an extensive root cause analysis of the incident, and this led to revision of guidance for critical care trainees, and the introduction of a new formulation of the drug, so that dilution is no longer required. Staff we spoke with were aware of the incident, and could demonstrate what changes had occurred in practice, accordingly.
- There was a robust system in place for reporting adverse incidents on the 'Datix' incident reporting system. Staff

we spoke with were familiar about when they should report an incident and how it should be done. We were assured that staff were reporting incidents appropriately.

- Learning from incident reporting was evident. Between May 2013 and May 2014, CCU had reported a pressure ulcer prevalence rate of 6.9%, which was higher than the England average of 6.4%. The manager told us that these incidences related to pressure ulcers on patient's faces due to ventilation masks, and we were informed that they were classed as unavoidable, however this is not accurate as measures were taken to prevent development. The service had introduced new face masks, which were considered to be contributing to the pressure ulcers; consequently, the equipment representative from the company supplying the masks was asked to come back and give further teaching sessions to staff. Senior staff told us that the service was going to be introducing new masks shortly. The service dashboard revealed that CCU had gone 57 days without a patient developing an avoidable pressure ulcer.
- Staff told us that they received feedback from the incidents that they reported. Managers received monthly Datix reports, which summarised all incidents that had been reported by the department. This information was routinely fed back to staff through the staff communication book to which all staff had access.
- There were weekly mortality and morbidity meetings within CCU. These were well attended and minuted. Trainee doctors were expected to attend and to contribute to discussions as part of their development programme. Specific leads for critical care also attended the monthly, trust-wide mortality committee meeting. There was evidence of dissemination of learning from these meetings to all staff.

Safety thermometer

- The safety thermometer results for the past ten months demonstrated that the service had no incidences of falls with harm, catheter-related urine infections, or venous thromboembolisms.

Cleanliness, infection control and hygiene

- The service had reported no MRSA infections in the last year. There were two reported cases of C.difficile infections between May 2013 and May 2014.
- Intensive Care National Audit & Research Centre (ICNARC) data from January to June 2013 showed low levels of infection in CCU. However, the trust was not able to provide more recent ICNARC data. Senior managers told us that this was because CCU had introduced a new critical care computer system, called MetaVision, which had led to a delay in uploading essential ICNARC data due to the transition.
- Both staff and external contractors used cleaning schedules to ensure that all areas were regularly cleaned. These cleaning schedules were displayed in the entrance foyer.
- All areas and equipment appeared clean and tidy. Staff practiced excellent hand hygiene, used gloves and aprons when required, wore uniforms above the elbows, and adhered to trust infection control policies. There was hand gel at the foot of every patient bed. These practices reduced the incidence of cross-infection.
- There was a prompting system at door entrances to the unit, which reminded everybody to decontaminate their hands prior to entry.
- The provider may like to note that not all equipment had the 'I am clean' green stickers. This made it difficult for staff to determine whether or not equipment was clean.
- The service was regularly monitoring infection control within CCU. We observed various infection control audits that had been completed. This demonstrated good infection control practices. During the past year, there had been 100% compliance with infection control practice in relation to catheter care. We observed catheter care which reflected these consistent results.

Environment and equipment

- CCU staff recognised trust patient isolation policies, whereby a patient should be nursed in a side room due to a high risk of spreading infection. It was noted that there were three occasions during May 2014 when, because of high bed capacity, patients with loose stools had not received a side room. Whilst no harm came to the patients the risk was present. Furthermore, coronary care patients could not be nursed in side rooms because there was not appropriate equipment available in the existing ones. We found that these issues had been highlighted on the service risk register. Senior managers explained that this issue had been discussed with infection control, who were already looking into finding a solution. We were told that portable side rooms were being considered; however, nor formal arrangements had been agreed.

Critical care

- The environment was bright and, given the limited storage facilities because of the age of the building, the department was well organised.
- Records for adult resuscitation equipment indicated that staff checked equipment regularly. The service conducted regular audits for safety of equipment. We found that equipment was in good working order and had been safety checked.
- We found some gaps in the checking of paediatric equipment, including resuscitation equipment. However, the equipment had been checked within the past week and was in safe working order on the day of our visit. Managers told us that the service had admitted two paediatric patients to CCU in the past year, and when this occurs, paediatric staff come in to CCU to provide critical care. We were concerned that there was a lack of clear responsibility in relation to the checking of paediatric equipment. We bought this to the manager's attention, and were reassured that immediate action would be taken.

Medicines

- Medicines, including controlled drugs, were stored safely and securely. Each patient bed had a locked medicines trolley nearby, which staff could access with a key card. This meant that patient-specific medicines were available promptly when required.
- We observed staff administer medicines safely. Records demonstrated that staff prescribed and administered medicines correctly.
- There was an effective system in place for ordering and disposing of medicines.
- The service was monitoring the management of controlled drugs. The controlled drugs records showed that night staff checked the balance of every controlled drug daily. Entries in the controlled drugs book were signed by two staff. This checking was part of the service's clinical dashboard.

Records

- In December 2013, the service introduced MetaVision. This is a critical care-specific electronic patient system. Staff appeared confident using the system, and one member of staff told us "now we are familiar with MetaVision, the system works really well for us".
- Managers told us that they had practised a system failure, and that the back-up contingency plan, which consisted of paper records, worked effectively.
- Three patient records were examined. We found records contained thorough patient medical histories, with clearly recorded diagnoses and/or investigations, with corresponding treatment plans.
- Appropriate, detailed and holistic risk assessments had been undertaken in all the records we observed. This included pressure ulcer, venous thromboembolism, nutrition and hydration, and levels of delirium assessments.
- Record keeping was of a high standard, contemporaneous, and in line with national guidance.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust provided staff with training on consent, the Mental Capacity Act 2005, and Deprivation of Liberty Safeguards (DoLS). Training for consent (37.31%), Mental Capacity Act and DoLS (58.21%) was significantly below the trusts target (70%). However, staff we spoke with demonstrated adequate understanding of these subjects and of the relevant legislation. Records confirmed that more staff were booked onto future training days on these subjects.
- The service used electronic records for cardio-pulmonary resuscitation decisions. We found that this electronic form did not reflect current national guidance issued by the Resuscitation Council (UK). This was because the form did not capture evidence that resuscitation decisions had been made in consultation with the patient or relative. We bought this to the manager's attention, and were assured that prompt action would be taken to correct this documentation. Staff were certain that either the patient or their relatives were always involved in resuscitation decisions. Staff told us that should a patient not be for resuscitation, and then be discharged to another area, the senior doctor would complete a paper 'do not attempt resuscitation' (DNAR) form, which would then follow the patient.

Safeguarding

- Staff were knowledgeable about their role in safeguarding, and confirmed that they had received safeguarding training in the past year. Staff were able to describe the different types of abuse, and correctly tell us what they would do if they thought someone was being abused.
- Records confirmed that 100% of critical care staff had received both adult and children's safeguarding training.

Critical care

- Information about the trust's safeguarding arrangements, including contact and referral details, were readily accessible for staff on the unit. There was a junior nurse who was appointed as the safeguarding keyworker for the unit.
- We observed staff acting appropriately to safeguard a patient with mental health concerns. This involved good communication, and suitable involvement with other members of the multidisciplinary team.

Mandatory training

- Staff said that they were up to date with their training, and felt equipped to provide safe care.
- With the exception of Mental Capacity Act and Deprivation of Liberty Safeguards training and training in the Mental Health Act, staff were compliant in moving and handling (100%), resuscitation (97.10%), fire safety (95.65%), infection control (95.65%) and tissue viability (100%). Mandatory training was extensive and reflected patient needs on the unit.
- Staff told us that they had protected time for mandatory training. Records confirmed this.

Assessing and monitoring risk

- We observed that there were suitable equipment, systems and processes in place to ensure that patients were assessed and monitored safely.
- The critical care outreach service supported the management of critically ill patients on wards across the hospital. The outreach service was a nurse-led service, which provided care in line with the trust's critical care outreach team operational policy. The policy was developed in accordance with national guidance issued by the National Institute for Health and Care Excellence (NICE) and the Department of Health. The team and the underpinning operational policy had been developed to support care delivery to sick and deteriorating patients across the trust; thus, aiming to decrease unnecessary CCU admissions, and escalating patients who required critical care.

Nursing staffing

- The CCU nursing establishment was calculated on occupancy of three level three, 10 level two, and three coronary care beds. This ensured that ratios of one nurse to two level two patients, and one nurse to one level three patient, were maintained.
- Records confirmed that there were enough suitably qualified members of staff with the right skill mix on duty to provide safe care at all times. One senior member of staff told us they were "fully staffed". Another nurse told us that staffing levels were "always good because people want to work here". However, nursing staff also told us that at times, they were expected to support other wards because of short shortages elsewhere. One nurse told us that this left them feeling vulnerable, because they did not feel comfortable in other areas, and did not always receive ward orientations. Another told us that they found this experience "scary".
- Planned and actual staffing numbers were displayed clearly for visitors near the nursing desk. Senior managers told us that there were two nursing vacancies and that new staff had already been appointed.
- A health care assistant (HCA) was employed to support nursing staff. Senior staff told us that one HCA was allocated to day shifts as a minimum. There was no routine HCA support through the night; however, staff told us that this could be arranged if required.
- Records clarified that staff sickness rates were higher than expected in March (5.14%) and April (5.53%) 2014, when compared to other areas of the hospital. Senior managers told us they were monitoring this, and had systems in place to fill shifts promptly with internal staff. Records confirmed that a few members of staff were on long-term sick leave. On the day of our visit, we observed that a staff nurse had called in sick, and that very shortly after this, the position was filled with another member of staff.

Medical staffing

- The department was led by a lead intensivist consultant, who was responsible for the operational aspects of care provision to patients. This post was in line with the Intensive Care Society standards.
- Overall, the critical care medical team consisted of eight critical care consultants, seven middle-grade doctors and an anaesthetist. One doctor told us that the Queen Elizabeth Hospital is "probably the best staffed intensive care unit I have ever worked on". We found that the service had sufficient consultants employed to deliver safe patient/consultant ratios, which reflected the Intensive Care Society standards.
- During night shifts, a middle-grade and a junior doctor worked within CCU, and an intensivist consultant was available on-call. A junior doctor told us that they "feel well supported at night".

Critical care

- Senior doctors told us that there was a consultant available 24 hours a day for critical care. Records confirmed this.
- We observed good and effective handover between medical colleagues. Doctors delegated work to one another, spoke clearly, and appeared to have a good rapport.

Major incident awareness and training

- The critical care service had a major incident plan, and numerous business contingency plans. We found that the service worked closely and liaised daily with the local Norfolk, Suffolk and Cambridge Critical Care Network. This meant that if a major incident occurred, patients could be transferred to other critical care units within the network. Senior managers said that although they have not had to do this previously, the service had admitted patients from other hospitals via the network in the past.
- The service demonstrated that it had learnt from previous major incidents. For example, following the past pandemic flu outbreak (Swine Flu), the service subsequently invested in more oscillator ventilators and had developed a pandemic flu escalation plan. This supported the service to cope with a similar future incident.

Are critical care services effective?

Good

Staff assessed people's needs, and delivered care and treatment in line with current legislation, standards, and national or internationally-recognised evidence-based guidance. The service was actively involved in national and local research and audit projects. The outcomes for people using the service were good, compared to other services, although due to the recent introduction of electronic patient records, the trust could not provide some information relating to patient outcomes.

Staff were committed to their work, and were highly motivated to provide patients with the best care possible. The trust supported staff to develop their professional capabilities, which enabled effective delivery of care and treatment. The trust supported and enabled multidisciplinary working within and between services across the organisation, as well as with external organisations.

Evidence-based care and treatment

- The trust's critical care policies and procedures reflected evidence-based guidelines. This included guidance issued by the Intensive Care Society, Department of Health, National Institute for Health and Care Excellence (NICE), and National Confidential Enquiry into Patient Outcome and Death (NCEPOD), as well as relevant medical bodies' publications.
- We observed care-giving, in line with trust policies and procedures.
- Policies we examined were up to date and had an established review date. There was an effective system in place for reviewing and updating polices. This was led by the department's practice development nurse (PDN). A senior manager told us that the PDN regularly reviews new guidance issued by NICE, and revises unit policies accordingly. The staff communication was then updated with relevant new guidance. This meant that evidence-based literature was disseminated effectively to all staff.
- The trust used care bundles to assist in the management of patient care. This included ventilator, tracheostomy, personal care, CVC insertion, CVC maintenance and sepsis care bundles. A care bundle is a group of clinical interventions which aim to improve patient outcomes.
- There was an allocated research nurse for the critical care department. Staff told us that "because we have a research nurse, we get involved in a lot of clinical research trials". The unit was involved in the Breath Study, in association with the University of Warwick, and in the PROMISE trial, which was a national sepsis trial. The service conducted a number of local audits monthly. Records confirmed this. We observed audits in relation to care bundles, equipment checks, documentation and infection control.

Pain relief

- Pain management was effective. Patients we spoke with told us that nurses frequently asked them about pain levels. One person said "they were quick to give me pain killers when I asked". Patients we observed appeared

comfortable. Patient's medicine, including some analgesia, was kept securely in bedside medicine cabinets. This meant that nurses had quick access to certain analgesia when the patient needed it.
- Electronic records confirmed that pain was assessed as part of the overall patient assessment, and this was accompanied by sedation scoring where relevant.

Nutrition and hydration

- Those patients who were alert had jugs of water close by. They told us that food and drinks were readily available. We observed that these patients were offered food choices inclusive of specialist dietary meals, such as halal and gluten-free. Staff told us that snack boxes were also available out of hours.
- Patients were receiving fluids intravenously, and as prescribed. Suitable mouth care was observed for those patients who required it.
- Nasogastric and total parenteral nutrition protocols were available for staff on the unit. Nurses demonstrated that they adhered to this guidance. The critical care link dietician attended ward rounds regularly from Monday to Friday, and provided regular specialist input into patient care.
- Records confirmed that patient's hydration and fluid balance were monitored appropriately.

Patient outcomes

- CQC's Intelligent Monitoring (which looks at a wide range of data, including patient and staff surveys, and hospital performance information) did not identify any outliers relating to critical care.
- The service collaborated with the Intensive Care National Audit and Research Centre (ICNARC). The service was unable to provide us with current ICNARC data relating to unplanned readmission within 48 hours. Senior managers told us that this because the service had recently introduced electronic patient records, which have taken precedence initially. This issue was presented on the services risk register. We were told that a Band 6 nurse and administrator were employed to ensure that ICNARC data was up to date.
- Mortality rates were within the expected range. ICNARC states that the expected standardised mortality ratio (SMR) for the unit is set at one. Records demonstrated that during the past 12 months CCU had a consistent SMR of less than 0.6.

Competent staff

- All staff attended a yearly emergency/critical care update day. There was a dedicated professional development nurse (PDN) who arranged this. Nurses we spoke with confirmed that they attended recently.
- Newly-starting nurses received sufficient protected supernumerary time, two allocated trained mentors, and were supported to work through a CCU development package. This ensured that all staff were competent and practised safely. Senior nurses told us that supernumerary periods were flexible and were extended as required.
- There was a structured induction programme for doctors, inclusive of a teaching programme consisting of the fundamentals of critical care.
- The service had arrangements to provide staff with supervision and appraisal. Staff confirmed that they received appraisals each year. Records demonstrated that appraisal rates were high. Only two nurses had not received an appraisal in the past year, and this was due to maternity leave.
- All the nurses that we spoke with had gained post registration awards, in either critical care or cardiac care, depending upon which area they worked in. Nurses were offered a choice to work in either part of CCU, and because of this continuity, it meant that nurses developed a relevant skill set and expertise in their field.

Multidisciplinary working

- There were a range of professionals available to support the care and treatment of people receiving critical care services. Physiotherapy input was available daily, and a dietician was available Monday to Friday. Daily multidisciplinary team meetings occurred on CCU.
- The critical care outreach team were available seven days a week, 12 hours a day. The team worked across the trust, and were available for advice, support and guidance on the management planning and treatment options of sick and deteriorating patients, in both ward and assessment areas.
- The outreach team also enabled and supported discharges from the unit, by supporting patients discharged from CCU and ward-based clinicians. Senior managers told us that the team follow up every patient who meets the 'step-down' criteria, and such patients receive between one and 15 follow-up visits.

Critical care

Seven-day services

- Critical care consultants were available 24 hours a day, seven days a week. This meant that they were able to attend a patient within 30 minutes, as set out in Intensive Care Society standards.
- Imaging services and physiotherapy were available seven days a week. There was an on-call pharmacist rota, which meant that critical care staff had access to pharmacy expertise at all times.

Are critical care services caring?

Good

Staff treated people with kindness, dignity, respect, compassion and empathy, while providing care and treatment. The trust involved people who used the service, and those close to them, as 'partners' in their care and treatment. Patients and their families were positive about the staff team. They said they were attentive and caring.

Staff supported people to make informed decisions. There was a wide range of information available for visitors. Staff provided patients, and those close to them, with the support they needed to cope emotionally with their care and treatment.

Compassionate care

- We observed that staff treated people in a warm and caring way. Patient's dignity was respected.
- Patients spoke positively about the staff in CCU. One patient said "staff are fantastic, absolutely marvellous". Another patient told us "I cannot fault any member of staff they are brilliant".
- CCU conducted a monthly family satisfaction survey. Past results were consistent and excellent. In May 2014, 96% of relatives/carers responses were satisfactory/very satisfactory. A total of 39 surveys were distributed, and 18 were returned. Copious positive comments from relatives/carers included "outstanding staff" and "care and treatment professional and excellent". There was one "not satisfied" response; however, the service took appropriate action following this issue being raised.
- There were 'Dignity in Care' posters displayed in the relatives' room. This reflected the Department of Health's 10 steps to recognise high quality services that respect people's dignity. There were also details for relatives and staff who wished to be a dignity 'champion'.

Patient understanding and involvement

- Patients and staff told us that there was good continuity of staff. One patient said "I have been in CCU a few times now following surgery and every time I get to know my nurse well, we call each other by first name".
- Medical staff spoke with patients and, where possible, involved them in elements of their care and decision-making processes. Patients who were able to speak with us confirmed that they were involved in their clinical care. One patient told us "they explain everything and ask if it is ok and what I want to do".
- Posters encouraged relatives and carers to be part of patient care. One poster read, 'Your opinion matters' and described how to give service feedback.
- We found that this electronic form did not reflect current national guidance issued by the Resuscitation Council (UK) on discussions with family members about resuscitation decisions. This was because the form did not capture evidence that the decision had been made with the patient or relative. We bought this to the manager's attention, and were assured that prompt action would be taken to correct this documentation. Staff assured us that all resuscitation decisions were made in consultation with the patient or family.
- Staff stated that should a patient be discharged to another area from CCU, then the doctor would, if appropriate, complete a paper record for a 'do not resuscitate' status; this would then follow the patient.
- Whilst there was a suggestion box in the relatives' room, the box was empty, and there were no comment cards or pens available.
- There was a wide range of information available for visitors, in the form of leaflets and posters. This involved information about reducing pressure ulcers, together with details on visiting times, safeguarding adults, organ donor services, and data protection. There was a child-friendly booklet, which explained CCU for children.

Emotional support

- Patients and relatives told us that staff were emotionally supportive. We observed staff being kind and attentive to patients and relatives. One relative had recently given service feedback, and had written "at this frightening time, the staff have been very helpful and very caring".

Critical care

- A senior nurse from CCU provided a follow-up outpatient clinic, and also visited patients who had recently been discharged from the unit to other wards. This follow-up work included an emotional assessment.
- If a discharged patient or inpatient was assessed as requiring further emotional support, the service referred patients to the trust psychiatric team for further psychological support.
- Posters and leaflets gave information to relatives and visitors about chaplaincy support and details. There was a 24 hour chaplaincy service available. The service was 'here for everyone, regardless of religion or belief'. There were regular services of worship in the 'Sacred Space' (an area in the hospital) offering services for Christians, Roman Catholics and Muslims.

Are critical care services responsive?

Good

The critical care service was responsive to the needs of most patients. The bed occupancy levels were better than the England average for parts of the previous year. However during May 2014 the critical care unit reached capacity and this was reflected on the units risk register. Local arrangements were in place to ensure that patients received the level of care that they required. A patient had recently described the discharge process as "chaotic" and staff confirmed that at times discharges were delayed due to medical and surgical outliers in ward beds.

Staff took account of people's needs and wishes throughout their care and treatment. Staff routinely listened to and learned from people's concerns and complaints, to improve the quality of care.

Service planning and delivery to meet

- The CCU bed occupancy rates between May 2013 and May 2014 had periods where bed occupancy were below the England average at 82.9%. However, during the month of May 2014 the CCU reached full capacity with no spare beds available. The change in capacity and demand had been escalated by senior managers, and reflected on the service's risk register.
- There was an escalation plan in place when bed capacity rose above a certain level. This involved reviewing the number of CCU beds available in the region, via the local critical care network, with a view to transferring patients, and discussing with the duty consultant the possibility of transferring patient's to wards if the patients were stable enough. Records confirmed that this escalation plan had been tried and tested. Senior managers stated that the service "copes well under pressure periods and has never had to transfer a patient to another CCU".

Access and flow

- Admissions were exclusively via referral from a consultant to an intensivist. This could be from any department in the hospital. Following admission, patients became the direct responsibility of the critical care team, and that continued during their entire CCU stay. It is noted, however, that the referring consultant input was still ongoing, along with alternative specialist advice, as was necessary.
- Managers told us that there were some delays in patient transfers and that this was due to outliers in ward areas and to full bed capacity throughout the wards. However they could not provide us with up to date data on this but provided us with ICNARC data from June 2013.
- Previous feedback confirmed that sometimes the discharge process from CCU was "chaotic". Following this comment from a patient, the service had introduced patient leaflets, which were adopted in an attempt to improve this process.
- Records confirmed that during the past 12 months, four elective operations, which required a post-operative critical care stay, were cancelled due to CCU bed shortages.

Meeting people's individual needs

- There was a translation service available 24 hours a day to support patients and relatives with limited English proficiency. Staff could access this service via the Patient Advice and Liaison Service, or through the trust telephone switchboard.
- A learning disability liaison nurse was available to support staff with patients with learning disability. One nurse told us that this role was very useful, and that the liaison nurse "comes in a timely way" when needed. A visitor told us that the learning disability support from CCU was "first class".
- Dementia awareness and learning disability training had recently been introduced to the mandatory training package. Of the critical care staff, 46.38% had received

dementia awareness training, and 70.15% of staff had received learning disability training. Records confirmed that there was allocated time for further staff to complete this training in the near future.
- There was a designated specialist nurse for organ donation onsite, who made organ donor arrangements, and supported patients and families with organ donor decisions.
- We saw examples of patient diaries, whereby staff nurses kept logs for patients when they were unconscious. This included details of the day, and photographs if the family consented. Clocks had the day and date on them. This meant that patients were reminded of what day it was.

Learning from complaints and concerns

- Information for people about how to make a complaint, raise concerns or compliment the service, were displayed where visitors would see it. The information included contact details for the Patient Advice and Liaison Service.
- Staff described the importance of dealing with people's concerns straight away, before they developed into more significant complaints. Staff said that when a concern was raised, this would be referred to the most senior nurse on duty, who would act to resolve the concern if at all possible.
- There were posters giving examples of how the service had listened to complainants, and taken appropriate action to improve the service. One complainant had raised concerns about patients who were situated in beds opposite the entrance, and stated that this did not ensure their dignity at visiting times. The service subsequently introduced screens, which were now put up in front of these beds during visiting hours.

Are critical care services well-led?

Good

The service had a clear vision and credible strategy to deliver high-quality care and promote good outcomes for patients. There was evidence of continual learning and improvement, to improve practice and support innovation. The trust took adequate steps to cascade vital information about incidents, complaints and achievements to all staff. Whilst medical staff felt as though they contributed to service design, nurses were less clear about how they could propose new ideas.

The leadership and culture within the organisation reflected its vision and values, encouraged openness and transparency, and promoted the delivery of high-quality care across teams and pathways. Staff worked well as a team, and felt supported by their line managers.

Vision and strategy for this service

- The trust had a clear vision and credible strategy to deliver high-quality, critical care services. There was a concise CCU service specification, inclusive of objectives, and a critical care outreach operational policy. Staff had a clear understanding of the trust's vision, values and objectives, which were displayed throughout the service.

Governance, risk management and quality measurement

- Incidents, complaints and audits were analysed and reported through the governance team to the board. There were regular reports distributed to critical care managers following this process.
- The service risk register was updated monthly and reflected current risks. Plans of action were tailored to each risk. This meant that the service was taking steps to manage risk appropriately.
- The service held governance meetings on a monthly basis. The meetings incorporated finance representatives, lead MDT personal, the nursing lead for CCU, and various other CCU professionals. These meeting were chaired by the lead intensivist.
- Following meetings, key governance themes were disseminated to all staff. There was a communication folder, which included meeting minutes, monthly incident summaries, audit outcomes, summaries of recent complaints, a policy update and evidence-based practice. A signatory page was included in the folder, for staff to sign once they had read key updates. Staff confirmed that they were aware of recent updates.
- There were various methods of quality assurance. The service dashboard included numerous audits, which were colour-coded (green, amber and red). If an area was highlighted at risk, it was displayed 'red', which alerted those scanning the dashboard. This enabled the senior managers to identify areas where action was

required. The service safety thermometer was another method used; it determined 'harm-free care', and was used to compare the service provided with that supplied by other areas of the hospital.

Leadership of service

- The critical care service was led by a matron and an intensive care consultant, in line with the Intensive Care Society standards. The service had also just employed a CCU nurse consultant, who was part way through the recruitment process.
- Nursing sisters led and co-ordinated shifts. At the entrance of the unit, there was a photo and name of the service nursing lead; this included a detailed description of the role of the sister, and described levels of senior nurse accountability.
- Staff spoke highly of senior managers. One member of nursing staff said "leadership is good" and another said that senior staff were "very supportive". Doctors that we spoke with shared the same views of both nursing and medical colleagues. One doctor told us that "the consultants are very approachable".
- Staff had access to newsletters in staff areas, which demonstrated that senior leaders disseminated learning, such as updates from the trust board. Staff told us that they regularly receive a blog from the chief executive (CEO) of the trust, via their trust email account. Staff said that the trust CEO was visible and approachable, and had started to lead positive change within the trust. One nurse gave an example of a letter they had received from the CEO, complimenting them on an episode of outstanding care.

Culture within the service

- We observed clear mutual respect between staff and across disciplines. Staff were motivated, proud and enthusiastic about their job. One member of staff said "it is a great place to work" and other said "the support here is fantastic".
- Staff were very busy, but the general atmosphere was good and people were cheerful.
- The service's successes and challenges were transparent. Staff were proud of the unit they worked on, but also recognised areas that required improvement.
- Staff told us that when they raised concerns to senior managers, "managers listen and do things about it". There was a trust whistle-blowing policy which staff had access to.

Public and staff engagement

- There were posters throughout the service which encouraged public involvement. This included various methods of service feedback. For example, there were details of who to contact if you have compliments or concerns. Another poster encouraged the public to give ideas about future research topics, based upon their experience of CCU.
- Medical staff told us that senior leads "value your opinion", and that "during mortality and morbidity meetings, junior doctors are encouraged to give opinions and get involved". Nursing staff were less clear about how they would get involved in giving service feedback and proposing new ideas.

Innovation, improvement and sustainability

- CCU had developed a flexible working arrangement with nursing staff. When the unit was quiet, a proportion of staff could go home and have leave time, although they were on-call and had to return to the hospital within an hour if they were required. Staff told us that this system worked effectively. This meant that the service did not rely on general bank or agency staff and was self-sustainable.
- Senior managers told us that they were "very proud because research and outcome in the department is phenomenal". We were shown varying examples of innovation, which led to improvements in equipment. There was an advanced subglottic drainage endotracheal tube, which one of the CCU consultants had helped to develop. The tube is used during mechanical ventilation. This equipment has since being used in CCUs in other parts of the country. Furthermore, a new arterial line had also been developed, with a three-way port, which had a lock and click device to ensure safe use.
- The service had introduced a weekly tracheostomy ward round, which involved input from an ear, nose and throat consultant.
- The practice development nurse and the outreach team worked hard to improve staff knowledge across the trust about sick and deteriorating patients. They offered a variety of courses which helped professionals and untrained staff to recognise and act appropriately when a patient's well-being deteriorated. The service

recognised that untrained staff completed most patient observations on the ward and in assessment units, and consequently, they developed a similar programme specifically for health care assistants.

Maternity and family planning

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

Information about the service

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust provides a full range of maternity services. There were approximately 2,418 births in the previous year.

The hospital provides care and treatment for women with low and high risk pregnancies. The service includes a delivery suite, one antenatal and postnatal ward, an antenatal clinic and a day assessment unit, and provides care during the antenatal, intrapartum and postnatal period.

In addition to maternity services being delivered at this location, there are also teams of community midwives and maternity care assistants (MCA), who deliver antenatal and postnatal care in women's homes, clinics and general practitioner locations across the county. The homebirth service was suspended in September 2013, and had not been reinstated at the time of our inspection.

We spoke with 22 midwives, 11 doctors, one medical student, four support workers, four student midwives, and six women who used the service, and their relatives.

Summary of findings

We judged that the maternity service required improvements to ensure that it was responsive to patients' needs and the leadership team addressed the known risks. Whilst both midwifery and medical staffing were below the trust's own minimal staffing establishment levels, the staff undertook additional shifts in order that patients received a safe service. The doctors we spoke with told us that the medical staffing levels impacted on training and personal development. The majority of staff were supported by senior management. However, the obstetrics team was disengaged, and the doctors told us that communication and support was poor from senior clinicians. The trust had a plan in place to address this.

Policies, protocols and guidance were based on and referenced nationally-recognised guidelines and standards. The trust had robust systems in place for the ratification of new policies and guidance. A variety of quality data was collected and analysed. From the data we reviewed, we saw that the trust was performing within expected limits.

All the women we spoke with told us that they had received good care, and we observed good staff interaction, which was polite and respectful. Women were given the opportunity to be involved in their care, and were given support as required. Two part-time midwives were responsible for caring for all the vulnerable women in the community. There were no individual specialist midwives addressing mental health

issues, the homeless, teenage pregnancies and substance abuse. There was no dedicated home birth or midwifery-led service available to women. A water birth was offered to women who were eligible to have a water birth; however, due to staffing levels, this was not always possible. There was one theatre in the delivery suite. This meant that women who had been booked for an elective caesarean section were often delayed, because emergency caesarean sections and other obstetric emergencies took priority.

Are maternity and family planning services safe?

Good

We found the service to be safe. There was a good reporting mechanism for reporting incidents and near misses. The environment, equipment, infection prevention processes and medicine management were all found to be adequate and safe. The trust had taken reasonable steps to ensure that women and babies were safeguarded against the risk of abuse. This was because there were processes in place, and training was available for staff.

Both midwifery and medical staffing were below the trust's own minimal staffing establishment levels. Midwifery staffing levels were adequate because gaps in the staffing levels were covered by the trust's bank midwives. The doctor's we spoke with told us that medical staffing levels impacted on training and personal development. Plans were in place to address these issues.

Incidents

- There was an effective mechanism to capture incidents, near misses and 'never events'. Staff told us that they knew how to report issues, both electronically, and to their manager.
- The robust governance framework positively encouraged staff to report incidents, and information on how to complain was visible to the people using the service.
- Learning and trends from incidents and complaints were disseminated to staff. We saw evidence that these were discussed in the service line quality and business board (SQaBB), and by the trust's clinical governance committee. We also saw that information was disseminated to staff through monthly newsletters, and was included in the communication folder held within each department. This meant that staff were able to learn from adverse events, to prevent reoccurrence of the incident or complaint.
- Monthly perinatal mortality and morbidity meetings were held. Staff explained to us that these meetings were used to present complex cases, and were also used as a forum for staff to discuss good practice, and to learn and improve on less good practice.

Maternity and family planning

Safety thermometer

- Safety thermometer audits were undertaken monthly, and the results displayed for staff to access the performance of each inpatient area. However, it should be noted that the areas covered by the monitoring tool, such as number of falls, pressure ulcers, and venous thromboembolism, do not accurately reflect maternity services.

Cleanliness, infection control and hygiene

- Maternity infection control rates were within a statistically acceptable range. During our inspection we saw that the environment was clean.
- Robust infection prevention and control audit programme are undertaken. This included weekly audits. The results were displayed in the clinical areas. The most recent results we saw showed us that staff adhered to infection prevention and control practices.
- Staff had access to personal protection equipment, such as gloves and aprons. Hand gel was available at the entrance to departments, and within the clinical areas.

Environment and equipment

- Delivery suite corridors were cluttered with equipment, in places; however, the corridors were wide, and this did not present an obstruction risk. Equipment was stored in the corridors because storage space was limited in the delivery rooms, and generally, in the delivery suite.
- Staff confirmed that equipment was available, and in sufficient numbers, and was well maintained. Housekeepers had responsibility for checking equipment, and ensuring equipment was serviced and repaired as necessary.
- On the whole, we found that suitable arrangements were in place to reduce the risk of harm from unsafe equipment.
- The majority of drugs were seen to be stored correctly and were in date; however, we found one drug in the delivery suite that was out of date. We pointed this out to the staff, and the drugs were removed.
- The monthly maternity newsletter, which is circulated to all areas, demonstrated that medication issues were discussed, and the newsletter included details such as patient information leaflets pertaining to medicines, and the appointment of an assistant chief pharmacist, with responsibility for investigating medication errors.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff confirmed that they had attended training on mental capacity assessment and consent.
- An audit of consent for caesarean section was conducted in May 2014. The results of the audit were not available to us during our inspection.
- Multidisciplinary meetings were held to ensure that decisions were made in the best interest of patients who did not have the capacity to make their own decisions.
- Consent and mental capacity assessments are discussed in the mandatory safeguarding training. Staff attendance at this training was good.
- The maternity records included a risk assessment for mental health and learning disabilities. The governance lead for maternity explained to us that these risk assessments were undertaken in early pregnancy.

Safeguarding

- Staff confirmed that they had attended training on safeguarding the vulnerable adult and child.
- The figures we reviewed for 2013/14 showed that 93% staff attended the safeguarding the vulnerable adult training, and 82% staff had attended the safeguarding the vulnerable child training.
- There were guidelines for staff to prevent infant & child abductions, and to maintain a safe environment. We also saw that there was a planned, unannounced skill drill, to test the process for preventing abductions.

Mandatory training

- Mandatory training included infection prevention and control, adult and neonatal resuscitation, safeguarding, information governance, health and safety, moving and handling, conflict resolution, and risk management. Figures for attendance in 2013/14 ranged from 71% to 96%.
- Staff also attended maternity-specific training, such as practical obstetric multiprofessional training, and understanding cardiotocography (CTG) recordings. We saw attendance was between 96% and 100% for this specialist training.
- We spoke with a variety of doctors, including consultants and doctors in training; they told us that attending training was difficult, because of the variance in senior cover in the delivery suite. This meant that they could not always attend training, because they could not always leave the delivery suite. Doctors explained that they attended monthly teaching sessions, but

weekly sessions held to review recent CTG recordings were not led by senior clinicians, were not multidisciplinary, were poorly attended, and did not always take place.
- Doctors were able to access their educational and clinical supervisors on a regular basis.
- We saw a training report dated June 2014, which informed the women and children's workforce scorecard. The report highlighted concerns with medical attendance at training. The practice development midwife was aware of the concerns, and was monitoring attendance and non-attendance at training, and had escalated their concerns to the clinical lead for obstetrics and gynaecology. The clinical lead explained to us that they were currently looking at the medical and senior medical cover.

Assessing and responding to patient risk

- There was no dedicated high dependency (HDU) provision on the delivery suite. Women with complex requirements were transferred to critical care. This meant that women received appropriate care; however, this was not ideal, because women were separated from their babies until they could be transferred back to the delivery suite.
- A modified early warning obstetric warning score (MEOWS) was in place. We saw that this tool was used by staff.
- At the time of our inspection, there was a vacancy rate for midwifery of 1.3 whole time equivalent (WTE). The head of midwifery told us that adequate staffing was a challenge for the trust. We undertook an unannounced visit at 10pm during our inspection, and found the staffing levels to be adequate. We also randomly selected staffing rotas from previous weeks and again found the levels to be adequate. No agency staff were used; however, internal bank staff were used at times to cover gaps in staffing.
- The birth ratio was one midwife to 30 women. Staff told us that one-to-one care was given to women in labour. On a minority of occasions, staff told us that this was a challenge. There was an escalation policy which detailed the process to follow should there be an increased demand. Midwives worked an on-call rota, and in busier periods, we saw that midwives were asked to work in the delivery suite. The on-call system was a new initiative, and during June 2014, the on-call system had been initiated on four occasions.
- Staff felt competent and supported to meet the needs of the women they care for. Staff were able to identify their supervisor of midwives (SoM).
- The head of midwifery told us that the SoM ratio to midwives was one in 17. The national guidelines recommend a ratio of one in 15.
- The head of midwifery explained that a business case had been submitted to the trust board, requesting an increase of 6.4 WTE in the midwifery staffing establishment.
- We observed a handover between shifts, and saw that it was robust and comprehensive. None of the doctors or midwives we spoke with voiced any concerns with the quality and detail of the handovers. All told us that they felt handovers were safe, and equipped staff to meet the needs of the women using the service.

Medical staffing

- There was good consultant presence between the hours of 9am and 9pm. The head of service explained to us that there was 40 hours of consultant cover each week. This was compliant with the Royal College of Obstetrics and Gynaecology (RCOG) safer childbirth recommendations. Locum doctors were used to ensure safe medical cover, because there were vacancies for middle-grade doctors, and one WTE vacancy for consultants. The head of midwifery and clinical director explained that there was a continual effort to recruit doctors. Some of the doctors we spoke with indicated that staff grade doctors were, at times, performing more senior roles.
- An internal review, and an external review by Health Education England (HEE), into medical staffing, had been conducted in May 2014. We saw that an action plan had been developed following the reviews, and HEE were monitoring progress against the implementation of the actions; in particular, senior cover to enable doctors to attend training and access to educational supervisors.

Major incident awareness and training

- We saw a maternity services escalation policy, which was current and up to date. The policy detailed what to do in the event of a situation which could affect the safe care of women and their babies. Midwives explained how they worked in the high priority areas, such as the delivery suite, when required to do so. There was also an on-call rota for out of hours, should more staff be required to meet the needs of patients using the service.

Maternity and family planning

Are maternity and family planning services effective?

Good

Policies, protocols and guidance were based on and referenced nationally-recognised guidelines and standards. The trust had robust systems in place for the ratification of new policies and guidance. A variety of quality data was collected and analysed. From the data we reviewed, we saw that the trust was performing within expected limits.

There was suitable monitoring of attendance and non-attendance at training. The majority of staff told us that they were supported in their role. However, staffing levels impacted on doctors attending training and support. There was multidisciplinary working on a day-to-day basis, during the shift handover of care, and in a variety of meetings and committees.

Evidence-based care and treatment

- Policies, protocols and guidance were based on and referenced nationally-recognised guidelines and standards. The trust had robust systems in place for the ratification of new policies and guidance.
- We saw regular review, and updating of policies and guidance. We spoke with staff and asked them if they were engaged in the development of policies, and how new guidance was communicated to them. One midwife explained to us that draft policies were circulated for comments prior to ratification.
- The trust's intranet contained details of all policies, and staff were able to access the documents. All the documents on the intranet contained a clear review date and version control. This demonstrated that all policies, protocols and guidance were current and up to date.
- All relevant National Institute for Health and Care Excellence (NICE) guidance was reviewed in the maternity guidelines group. When new NICE or national guidance was published, the maternity guidelines group discussed implementation, or demonstrated the rationale as to why the guidance was not implemented.
- A variety of audits were conducted within the maternity service. We saw an audit programme for the coming year, and saw that the outcome of audits was discussed at the service line quality and business board (SQaBB), and by the trust's clinical governance committee. This meant that audits were conducted, findings analysed, and new practices embedded, to improve outcomes for the women using the service.

Pain relief

- A wide range of pain relief was available to meet the individual needs of women. These included epidural analgesia, opiates and nitrous oxide (gas and air), paracetamol and the use of water (water births).
- There were dedicated anaesthetists, who attended the multidisciplinary handovers, who provided excellent epidural cover.

Nutrition and hydration

- The vast majority of women in the maternity unit are healthy and well, and are able to access food and fluids as they need them. However, we saw evidence of newly-developed food and fluid balance charts in use for women following instrumental, caesarean section births, or for women who were ill. We noted that these helpfully identified fluid and soft food intake, such as ice cream, jelly and soup, and how to record them.

Patient outcomes

- Monthly quality outcomes were displayed in clinical areas. This meant that the trust were able to action performance concerns, and staff were able to understand what they were doing well, and where improvements were required.
- Maternity quality performance measures were discussed at the service line quality and business board (SQaBB), and by the trust's clinical governance committee.
- From the data relating to elective caesarean sections, emergency caesarean sections, puerperal sepsis, one-to-one care in labour, maternal readmissions, and neonatal readmissions, we saw that the trust's outcomes were within expected limits.

Competent staff

- Midwifery, support staff and student midwives told us that they were able to access a variety of mandatory training, and there were opportunities for further development. This training included formal courses and emergency skill drills.
- Some medical staff explained that they were not always able to attend training; this was mainly due to the timing of the training sessions, and staffing levels. However, other medical staff told us that they were well

supported, had a good induction processes, and could access regional training and support through the local education and training boards (LETBs). These are organisations that are responsible for the education and training of health and public health workers at a regional level.

- The review by Health Education England (HEE), in 2014, identified that doctors should be able to access clinical and educational mentors, and have weekly one-to-one meetings with their mentors. This was being addressed by the trust, and monitored by HEE.

Multidisciplinary working

- There was a robust governance committee structure, which included multidisciplinary working. The SQaBB reported into the clinical governance committee. The clinical governance committee was accountable to the trust board, and had responsibility for risk management and governance. The SQaBB was attended by midwives, obstetricians, paediatricians and paediatric nurses.
- Perinatal mortality and morbidity meetings were held bi-weekly. These meetings were held to discuss complex cases or areas of concerns. These meetings were also multidisciplinary, and involved staff with particular expertise.
- During the inspection, we attended the delivery suite handover. There was also a similar handover on the wards; however, we did not attend these handovers. The handover meetings were attended by obstetricians, middle-grade and doctors in training, midwives, anaesthetists and the governance and risk midwife. However, these meetings were not attended by paediatricians. On the whole, this meant that there was a multidisciplinary understanding of clinical risks at each shift handover.

Seven-day services

- There was a good consultant presence between the hours of 8am and 5pm. After 5pm, there was an on-call consultant, and the maternity unit was staffed by a registrar and a senior doctor in training. The detailed handover at each shift determined what the needs of the service were, and there was a midwifery on-call service available should further staff be required.
- Closure of the delivery suite was monitored through the SQaBB, and documented on the performance and governance scorecard. The delivery suite was closed a total of seven times in April and May 2014. A senior midwife explained that during these times, women were admitted to neighbouring maternity units, as necessary.

Are maternity and family planning services caring?

Good

All the women we spoke with told us that they had received good care, and we observed good staff interaction, which was polite and respectful. Women were given the opportunity to be involved in their care, and were given support as required.

Compassionate care

- All the women we spoke with told us that they were happy with their care. One woman told us “I had a good relationship with my midwife and had one-to-one care in labour”. During our inspection we also saw good staff interaction, which was polite and respectful.
- We saw evidence that the Friends and Family Test was carried out, and the results were displayed in the clinical areas. We saw that women and their families were able to comment about their experiences. The Friends and Family Test, and women’s comments, were accessible to staff, and reported through the clinical governance committee structure. We saw that the Friends and Family Test was generally positive and comparable, both in response rates and outcomes, to the national average results.
- The CQC maternity survey results for 2013 showed that performance against the national average was better than other trusts for the questions: 'Were you treated with dignity and respect?' and 'Did you have confidence and trust in the staff caring for you during labour and birth?' In all other areas, the trust performed the same as other trusts.

Patient understanding and involvement

- The women we spoke with told us they felt involved in their care. Women and their partners told us that they had taken part in making decisions and felt supported in their care. We saw that antenatal patients had their maternity notes to hand when in the hospital.
- Women were generally seen about a month before they were due to give birth, and a joint discussion was held

to discuss women's hopes, wishes and plans for the birth and postnatal period. All the women we spoke with told us that they were involved in decision-making, and were well prepared, and were given information leaflets to read when at home.
- Women had contact details of their community midwife and the hospital, should they require support and guidance during their pregnancy, birth and postnatal period.

Emotional support

- There was a dedicated room on the delivery suite for parents to stay in when there had been a sad outcome to their pregnancy and birth. The room was self-contained with a kitchenette, ensuite facilities and a double sofa bed. We visited the room during our inspection and found the room to be adequate; however, the room was clinical in appearance. We spoke with one midwife who explained that the staff had been fund-raising, and hoped to refurbish the room shortly.
- The midwife with special interest in bereavement and emotional support had recently retired. At the time of our visit, this role was being undertaken by midwives on an ad hoc basis. We saw that the post had been advertised, and preparation for interviews was underway.
- We spoke with a chaplain who felt that there was a good relationship with the maternity services. They told us that emotional and spiritual support were available to families as required.

Are maternity and family planning services responsive?

Requires improvement

Two part-time midwives were responsible for caring for all the vulnerable women in the community. There were no individual, specialist midwives for mental health issues, the homeless, teenage pregnancies and substance abuse.

There was no dedicated home birth, or midwifery-led service, available to women. A water birth was offered to women who were eligible to have a water birth; however, due to staffing levels, this was not always possible. There was only one theatre in the delivery suite. This meant that women booked for an elective caesarean section could be delayed, because emergency caesarean sections and other obstetric emergencies took priority.

Parent education classes were offered in the community for women from Latvia, Russia, Poland and Lithuania. Each of the sessions held included a translator. This meant that women, whose first language was not English, had the opportunity to receive education and information which they were able to understand.

Service planning and delivery to meet the needs of local people

- The staff had a good understanding of the population who used the service, and were all able to explain with confidence the requirements of the people who were inpatients.
- At busy times, staff were re-deployed to the delivery suite. A senior member of the midwifery team explained that when there was a peak in activity, clinical care was prioritised, and staff were moved to ensure the safest care possible was delivered.
- There was an escalation policy, and the staff we spoke with understood the process. We spoke with a number of community midwives, who were very clear where they would be deployed to, and how many hours they were able to work to ensure they remained within the limits of safe working.
- Staff told us about an excellent parent education service. Parent education classes were offered in the community for women from Latvia, Russia, Poland and Lithuania. Each of the sessions held included a translator. This meant that women, whose first language was not English, had the opportunity to receive education and information which they were able to understand.

Access and flow

- From time to time, the delivery suite and the day assessment unit (DAU) had closed, due to the high demand for care and treatment, and the capacity of the hospital to deliver the care safely. The closure rates were monitored though the SQaBB and the clinical governance committee, and had exceeded the trust's own quality parameters. The delivery suite had closed

seven times in April and May 2014, and the DAU had closed five times in the same period. This meant that access to services was not always possible, and women had to travel to neighbouring hospitals.

Meeting people's individual needs

- Staff had access to interpreters, and could access the Language Line service. The majority of staff told us that they used this service when required, and found it useful. The staff were able to explain with confidence the most common languages used in the area.
- Information and leaflets were visible in most areas, with the exception of the delivery suite. However, all the women we spoke with told us that they had access to information. Leaflets were easily accessible in different languages.
- The specialist midwife for safeguarding told us that they provide care and support for 25% of the pregnant population in the area. They saw women who had a variety of complex needs, such as mental health issues, homelessness, domestic violence, teenage pregnancies, previous and new safeguarding concerns, and substance abuse. The trust employed two part-time midwives to provide care and support for the most vulnerable of women in the area. This meant that the service was over-stretched. Despite the exceptional dedication of the two midwives, the most vulnerable women may find it difficult to access the care they required.
- Antenatal clinics had been expanded to accommodate increased demand. For example, we noted that a clinic was held every week, for vulnerable women with a variety of complex health and social needs. Many women with complex needs often find it difficult to attend clinics at hospital. The specialist midwife we spoke with told us that very often, they have to access women in the community and follow-up non-attendance at clinic appointments. This meant that an already over-stretched service was required to carry out further duties.
- A 'vaginal birth after caesarean section' clinic had been set up by a committed midwife. The aim of the clinic was to reduce the caesarean section rate, and encourage women to choose a more natural birth, if safe to do so, following a previous caesarean section birth. This meant that the trust was taking positive steps to reduce the caesarean section rate.
- The home birth service had been suspended since September 2013. The service had identified this as a risk and we saw that it was included on the risk register. Risks to the delivery of high quality care were identified, analysed and some controls put into place. Key risks and actions were reported through the governance structure, and reported to the board. The identified risks of inadequate staffing, and the suspension of the home birth service, were clearly documented on the risk register, and discussed at SQaBB, and by the clinical governance committee. A public consultation exercise is being planned following which the trust will consider a range of options.
- There was no dedicated midwifery-led unit (MLU) available to women. The midwives we spoke with told us there were plans to modify the environment in the delivery suite to ensure there were three rooms available for women with low risk pregnancies. There was no definite timescales for the development of the MLU, and the midwives were unclear on how the trust planned to ensure that there was a dedicated MLU in the future.
- There was a dedicated room with a pool for women to have a water birth. Due to staffing levels, at times, women were not offered this facility. One woman we spoke with told us that their care had been good, but they were disappointed they could not have a water birth, due to the number of staff available at the time of their birth.
- There was a dedicated theatre team available 24 hours a day, including out of hours, such as at night or at weekends. The doctors we spoke with raised concerns that there was only one theatre in the delivery suite. This meant that women booked for an elective caesarean section could be delayed, because emergency caesarean sections and other obstetric emergencies took priority.
- The trust had received the United Nations Children's Fund (UNICEF) level 2 accreditation for the Baby Friendly Initiative. This initiative supports breastfeeding and parent infant relationships by improving standards of care.

Maternity and family planning

Learning from complaints and concerns

There was a robust complaints process in place, and we saw evidence of learning from these complaints and concerns. We saw complaints, and learning from complaints, were discussed at the SQaBB and by the clinical governance committee.

Are maternity and family planning services well-led?

Requires improvement 

Risks to the delivery of high quality care were identified, analysed and controls put into place. However, the identified risks of reduced staffing, and the suspension of the home birth service, had insufficient controls in place to mitigate the known risk.

The majority of staff told us that they were supported and senior managers were visible. However, the doctors we spoke with told us that the obstetrics team were disengaged, and communication and support was poor. This impacted on the care received by women and the longer term strategy for the department.

Vision and strategy for this service

- During the staff interviews and focus groups, the vision and values of the trust were not clearly identified by staff. Staff explained to us that there had been several years of uncertainty, and the trust board had not been inconsistent for some time. However, the majority of staff went on to tell us that the present chief executive was visible and approachable. Staff were able to show us that they had access to the chief executive's weekly blog, and communication was improving. However there were no clear plans to make the service more accessible to women.

Governance, risk management and quality measurement

- We saw a robust governance framework and reporting structure. Incidents, serious untoward incidents, complaints, risks and audits were analysed, and reported through the committee structure to the board. We saw that quality data was also displayed in the clinical areas. This meant that staff had opportunities to understand trends, learning and changes to practice.
- Risks to the delivery of high quality care were identified, analysed and some controls put into place. Key risks and actions were reported through the governance structure, and reported to the board. The identified risks of inadequate staffing, and the suspension of the home birth service, were clearly documented on the risk register, and discussed at SQaBB, and by the clinical governance committee. We found insufficient evidence to show us that robust long-term controls were in place to mitigate the risk.

Leadership of service

- The medical staff we spoke with told us they did not always feel supported by senior colleagues. One doctor told us “there is variable consultant presence on the delivery suite and there can be communication difficulties between teams”. We raised our concerns, about the leadership amongst the medical staff, with the clinical director. They explained the issue had been raised and an internal inquiry had been undertaken, and there were plans in place to improve working relationships and support.
- The midwifery and support staff we spoke with told us that they had good support from ward managers and modern matrons. Midwives also had 24 hour access to supervisors of midwives.
- The head of midwifery was also the clinical director and associate chief nurse for two other directorates. We asked whether such an extensive role was achievable. They explained that it was a challenging role, but they had good senior support, and were able to delegate some of the responsibilities to the clinical leads in obstetrics and paediatrics. However, one clinical lead explained to us that they felt over-stretched at times, and unsupported.

Culture within the service

- The majority of staff told us they felt supported, and had access to more senior staff when required. Staff told us they were able to raise problems and concerns without fear of discrimination, and managers and modern matrons were accessible.
- We spoke with a number of student midwives, support workers and midwives in their preceptorship year, and all told us they worked in a supportive environment, and had regular access to mentors and preceptors.

Maternity and family planning

- Many of the doctors we spoke with talked about a disengaged obstetrics team. The majority of doctors in training told us that communications and team working were lacking.

Public and staff engagement

- We saw evidence that women, families and staff were engaged and their views sought. The majority of comments from women and their families were positive, about the care and experience received.

Services for children and young people

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

Information about the service

We spoke with nine nurses, five support workers, including a play specialist, one student nurse, three consultants, three doctors, one medical student, 12 parents and four children. A paediatric service for children ranging from 0-16 years of age is provided at the hospital, including: A 23-bedded, acute general paediatric ward including a five bedded paediatric assessment unit (PAU). This takes referrals from GPs, and accident and emergency. This is open Monday to Friday, 9am-5pm. It was open full time during the winter, but is not currently funded for full time working at present. The ward also includes a high dependency area, which can care for a maximum of two patients at any one time. The services also consists of: a purpose-built outpatients department, providing a large range of clinics, both for internal and visiting consultants, community paediatricians and allied health professionals, such as occupational therapists, a seven bedded elective and day case service, a neonatal intensive care unit (NICU), which has 12 cots available for babies requiring intensive care, high dependency and special care. The unit is classified as a local neonatal unit within the Eastern Neonatal Network. The community neonatal outreach service is co-located on the unit.

The Level 1 paediatric oncology shared care unit (POSCU) with Addenbrookes Hospital, Cambridge, as the principal treatment centre. There is an open access policy for urgent medical review for febrile neutropenia, nutritional support and blood products. End of life care, and bereavement support for patients and families, are provided in conjunction with the Children's Hospice in Quidenham.

There is a paediatric eye service, including an orthoptist and a consultant paediatric opthamologist. An emergency service is located in the accident and emergency department, and has links to inpatient paediatric beds. The in-patient service is available seven days a week and provides 24 hour cover. There are 6.4 whole time equivalent consultants, some of whom have specialist interests.

Services for children and young people

Summary of findings

The service required improvement to ensure that it protected the patients from avoidable harm. Equipment was not always checked, serviced and clean; in particular, the paediatric resuscitation equipment in other areas, such as A&E and critical care. There were areas within the neonatal unit which were cluttered. Nursing staff did not have access to regular clinical and safeguarding supervision. Nurse staffing was insufficient in both the neonatal and the paediatric unit. Staff had access to training, education and support.

There was good working relationships between the NICU and the paediatric service including multidisciplinary team working. We found that the care and treatment of children, and support for their families, was flexible, empathetic, and compassionate. Advanced neonatal nurse practitioners provided a responsive service to babies and their families, with NICU also offering a valuable support to babies transferred home with oxygen and feeding support. Staff across the service promoted and maintained the dignity of children. Care and treatment plans were individualised. Needs were assessed, and the care plans reflected the needs well.

There was uncertainty between the staff groups about what the vision for the service was. We saw effective and committed leadership at team and senior clinician level, and staff told us they were generally well supported by their managers.

Are services for children and young people safe?

Requires improvement

Children and young people's services required improvement because equipment was not always checked, serviced and clean; in particular the paediatric resuscitation equipment. There were areas within the neonatal unit which were cluttered which could impact upon care given.

Nursing staff did not have access to regular clinical and safeguarding supervision. Nurse staffing was insufficient in both the neonatal and the paediatric unit. Despite this being on the risk register action was yet to be taken to ensure that patients are protected from avoidable harm.

Incidents

- There was an effective mechanism to capture incidents, near misses and 'never events'. Staff told us that they knew how to report incidents, both electronically, and to their manager. We saw that a robust governance framework was in place, which positively encouraged staff to report incidents, and information on how to complain was visible to the people using the service.
- We asked staff to explain how learning from incidents and complaints was cascaded to all staff. Their responses indicated to us that learning, and trends from incidents and complaints, were disseminated to staff. We saw evidence that these were discussed in the service line quality and business board (SQaBB), and by the trust's clinical governance committee. The paediatric governance lead and lead nurse explained to us that monthly ward meetings were held to discuss learning from incidents. We also saw an example where learning and additional training had taken place following a medication error.
- Monthly perinatal mortality and morbidity meetings were held to present complex cases, and were used as a forum for staff to discuss good practice, and to learn and improve on less good practice within the women and children's directorate.
- The trust had plans for the clinical governance midwife, who had responsibility for the quality and governance

framework with the women and children's division, to work shifts on the paediatric ward and the neonatal unit. This meant that staff would be able to discuss any concerns regarding incidents.

Cleanliness, infection control and hygiene

- The data we reviewed suggested that maternity infection control rates were within a statistically acceptable range. During our inspection we saw that the environment was clean.
- We saw that a robust infection prevention and control audit programme was undertaken. The results were displayed in the clinical areas. The most recent results we saw showed us that staff adhered to infection prevention and control practices.
- Staff had access to personal protection equipment, such as gloves and aprons, in all the departments we visited on our inspection. We also saw that hand gel was available at the entrance to departments, and within the clinical areas. The vast majority of staff were observed using the hand gel. However, we did see one member of staff who failed to cleanse their hands when entering the ward.

Environment and equipment

- Generally, the environment was clean, bright and suitable for children and young people, and catered for children and young people of different age groups. We found that two bays in the neonatal intensive care unit (NICU) were cluttered with equipment. This meant that storage for equipment in the neonatal unit was inadequate, and could pose a risk to staff and patients.
- We spoke with staff, and all confirmed that there was sufficient equipment, which was readily available for use. We found that some equipment had not been serviced within the specified time. For example, we saw an incubator in the NICU which should have been serviced in February 2014, and a resuscitaire that should have been serviced in May 2014.
- We found that a majority of paediatric equipment was checked and clean. However, this was not the case for paediatric resuscitation equipment. For example, the resuscitation trolley in the NICU had not been checked on seven days in June 2014, five days in May 2014, and eight days in April 2014. The paediatric resuscitaires in the adult critical care unit and general theatres had no record of being checked, and the resuscitaire in critical care was stained with an unidentifiable liquid. We pointed this out to senior managers at the time of our inspection, and asked for it to be rectified immediately.

Medicines

- We randomly selected medication and prescription charts, to ensure that medication was stored correctly, in date, and prescribed and administered correctly. We found that medication was in date, and stored correctly. All the prescription charts we viewed were completed correctly. We found one drug to be out of date by three days on the paediatric ward, and this was removed by staff.
- Nursing staff explained to us that medicine management was included in their induction training. The trust also required staff to complete a competency workbook, and to be assessed prior to being able administer medication to patients.

Records

- We looked at a number of records, and found them to reflect the care given in the care plan. All care plans were up to date. Each entry in the records was dated and timed, by the relevant health professional.
- Records were generally well maintained. One set of notes we looked at were in a poor state of repair. This was addressed with the ward clerk, at the time of our inspection, by the nurse in charge.

Consent

- We saw a standardised consent form, with space for parent, carer, child or adolescent to sign or co-sign.
- We saw that staff were able to access an e-learning module, in awareness of mental capacity and paediatric issues linked to consent. The practice development nurse explained that all staff completed this module.

Safeguarding

- We asked a number of staff to describe the training they had received in relation to safeguarding the vulnerable adult and child. All staff told us that they had received the appropriate training. We reviewed the training records, and saw that in April 2014, 82% of staff had attended safeguarding children training, and 93% had attended safeguarding the vulnerable adult training.
- There was also a designated doctor and nurse for safeguarding available to assist staff, should they require support and guidance. There was also a safeguarding traffic light process, which guided staff on

how to escalate concerns, depending on the nature of the safeguarding issue, with contact details of social services, and when to contact medical and senior clinicians. Staff reported that this system worked very well.

- Staff were only offered safeguarding supervision on an ad hoc basis, rather than being provided with a regular session of protected time in which to discuss safeguarding issues. There were plans to recruit a further safeguarding nurse, to address the training and supervision of staff. However, at the time of our inspection staff did not receive regular safeguarding supervision.

Mandatory training

- We reviewed the women and children's division mandatory training figures. We saw that mandatory training included infection prevention and control, adult and neonatal resuscitation, safeguarding, information governance, health and safety, moving and handling, conflict resolution and risk management. Figures for training attendance in 2013/14 ranged from 77% to 96%.
- We asked a number of staff to describe the mandatory training they had received. Staff demonstrated to us that they had received appropriate training.

Management of deteriorating patients

- A paediatric early warning score (PEWS) was in place. This is a tool to quickly determine the degree of illness of a patient and the escalation process to senior doctors. We saw this tool was used by staff.
- The paediatric ward had two high dependency beds. The practice development nurse explained to us that staff received high dependency training to ensure there were staff available to care for patients with complex care needs.

Nursing staffing

- We spoke with staff and asked them if they had enough staff to meet the needs of their patients. All told us that they felt they did not have the required amount of staff.
- The NICU was not adequately staffed and in line with the British Association of Perinatal Medicine (BAPM) standards for the necessary nursing skills. The trust's clinical performance and governance scorecard showed that in April and May 2014, the NICU fell below the BAPM standards 10 times. A senior nurse explained to us that the paediatric unit was also understaffed by 2.5 whole time equivalent (WTE) paediatric trained nurses. In January 2014, the estimated shortfall of nurses was 6 WTE. Nurses had been appointed since January, but they were not all paediatric trained nurses.
- We carried out an unannounced inspection at 10pm, and found the paediatric ward and the NICU to be staffed adequately. However, the staff on both the NICU and the paediatric ward explained and showed us that staffing was not always adequate. We saw from the rotas we reviewed that bank staff were used on a regular basis to cover gaps in the staffing levels.
- The trust had identified staffing to be a significant concern, and had included it on the risk register. The risk register was reviewed, both within the division, and through the trust's clinical governance committee. However, the lack of staff remained a risk at the time of our inspection.

Medical staffing

- We spoke with a number of doctors. All of them told us they had good working relationships which were supportive.
- Doctors in training and medical students explained they had protected time to access training, education and supervision. One doctor told us that it was normal practice for consultants to teach junior doctors two to three times a week.
- The clinical director described the paediatric medical team as a team which worked well together and engaged with each other. None of the staff we spoke with raised any concerns regarding the numbers of medical staff. Both nurses and doctors in training told us that consultants were always available when asked to review the care and treatment of patients.

Are services for children and young people effective?

Good

Children and young people's services were effective despite nursing staff not having regular access to planned supervisions. We also found that the staff appraisal rate in 2013/14 fell below the target of 90%. There were good working relationships between the NICU and the paediatric service, including multidisciplinary team working.

Services for children and young people

Evidence-based care and treatment

- We saw that policies, protocols and guidance were based on and referenced nationally-recognised guidelines and standards. The trust had robust systems in place for the ratification of new policies and guidance. We also saw regular review and updating of policies and guidance.
- The trust's intranet contained details of all policies, and staff were able to access the documents. All the documents on the intranet contained a clear review date and version control. This demonstrated that all policies, protocols and guidance were current and up to date.
- All relevant National Institute for Health and Care Excellence (NICE) guidance was reviewed in the paediatric and NICU clinical governance meetings. When new NICE or national guidance was published, the group discussed implementation, or demonstrated the rationale as to why the guidance was not implemented.
- We saw that a variety of audits were conducted within the service. We saw an audit programme for the coming year, and saw that the outcome of audits were discussed at the paediatric and NICU clinical governance meeting, and by the trust's clinical governance committee. This meant that audits were conducted, findings analysed, and new practices embedded to improve outcomes for the patients using the service.

Pain relief

- The records contained a good pain relief scoring system, and evidence of it being used appropriately. We also saw that the symptom management team in pain and symptom relief were involved, where appropriate.
- Staff told us the pain assessment score had recently been reviewed and amended, so that it was easier to use.

Nutrition and hydration

- There was evidence of accurate food and fluid balance charts in the nursing records.
- Staff told us about a previous incident reported, where there had been an incorrect recording of weight on admission to A&E, which affected the calculation of medication. We saw that learning had taken place from the incident, and weight and body mass index measurement were always undertaken and recorded on admission to the ward.
- Generally, breastfeeding mothers were offered meals during their child's admission to hospital. However, one mother explained that they had not been offered a meal since their child's admission the previous day. Offering meals for breastfeeding mothers is considered good practice.

Patient outcomes

- The paediatric service participated in a variety of clinical audits, including the national neonatal audit programme. From the audit report presented to the clinical governance meeting in June 2014, we were able to confirm that 23 audits were planned, including national and local audits. Completed audits, the findings, and recommendations, were also reported through this committee. An example of this was the paediatric diabetes audit. We discussed the findings with the clinical nurse specialist for diabetes, and they explained that an action plan had been developed to address the findings of the audit.
- Patient outcomes were also measured on the clinical performance and governance scorecard. For example, we saw how the trust collected data on the number of babies requiring intensive and high dependency care, and the number of babies receiving breast milk.

Competent staff

- Nurses, support staff and student nurses also told us they were able to access a variety of mandatory training. Doctors in training and medical students explained they had protected time to access training, education and supervision.
- The number of staff in the children's service, who had received an appraisal in 2013/14, was 91% overall. However some areas were as low as 50-60% The trusts target for areas was 90% of staff in the division should have received an appraisal, however not all areas were achieving this.

Multidisciplinary working

- We saw a robust governance committee structure, which included multidisciplinary working. The governance meetings reported into the governance committee. From the minutes we reviewed, we saw the meetings were attended by paediatricians, paediatric nurses, midwives and obstetricians.

- We also saw that perinatal mortality and morbidity meetings were held. These meetings were held to discuss complex cases or areas of concern. These meetings were also multidisciplinary and involved staff with particular expertise.
- There were good multidisciplinary relationships between paediatrics and the neonatal services.
- Children and neonatal community nurses were based in the inpatient services. They attended daily handover within the NICU, and when community patients were admitted to the paediatric ward, to ensure they were aware of patient's needs, and were able to plan for their discharge. The children's community nurse explained to us that for children with complex needs, a multidisciplinary meeting was held prior to discharge home.
- Children and families were visited before leaving hospital, and care pathways were developed. We saw evidence of risk assessments being carried out in the home prior to discharge. This meant that discharge was planned, and families were prepared for care and support within the community environment.
- There was sometimes a delay in referring paediatric patients to the child and adolescent mental health services. However, this service was not provided or commissioned by the trust.
- The Children's Acute Transport Service (CATS) provided the regional retrieval service for paediatric patients requiring intensive care therapy. Children were cared for in either adult theatres, or the adult critical care unit, whilst awaiting transfer. The retrieval service was based in London, which meant that the transport could take several hours. The consultants we spoke with explained that this could be a challenge at times.
- There was no formal transition pathway from children's services to adult services. The children's community nurse explained that transition between the services was dealt with on an individual basis. They went on to explain how the transition pathway was being assessed and reviewed nationally, and required a nationally-recognised pathway to be developed to ensure consistency of care.

Seven-day services

- The inpatient service is available seven days a week and provides 24 hour cover, with the exception of the paediatric assessment unit (PAU), which was only available Monday to Friday. There are 6.4 whole time equivalent (WTE) consultants, some of whom have specialist interests.

Are services for children and young people caring?

Good

We found the care and treatment of children, and support for their families, was flexible, empathetic, and compassionate. Staff across the service promoted and maintained the dignity of children.

The majority of parents and children we spoke with told us they received good communication and had an understanding of the plan of care.

Compassionate care

- We found the care and treatment of children, and support for their families, was flexible, empathetic, and compassionate. Staff across the service promoted and maintained the dignity of children. Staff ensured confidentiality was maintained when attending to care needs. We found staff had developed trusting relationships with parents and representatives that focused on maximising children and young people's independence.
- Each child and family's culture, beliefs and values had been taken into account in the planning and delivery of care. Staff told us about an incident and complaint where a family had been offered food which, because of their cultural beliefs, they were unable to eat. We saw evidence that the complaint had initiated an investigation, and as a result, all children and their families were asked on admission to express their cultural and dietary preferences.
- The majority of families we spoke with could not praise the quality of care highly enough. One parent told us "the care is outstanding. My child has been an inpatient on and off for some time. We are always offered a side room because of my child's clinical needs". Another parent told us "the care is brilliant, staff are attentive to our needs".

- One doctor told us "the nurses act as advocates for the patients and will challenge if they feel decisions and care planning is inappropriate. The nurses always protect their patients". This meant that patient's rights were protected by the staff caring for them.
- The paediatric ward was involved in the Friends and Family Test, and scored extremely well.

Patient understanding and involvement

- Staff delivered child-centred care within all their services, and children and their parents were involved in and central to all decisions made about the care and support needed. Parents and children had an understanding of the child's care and treatment.
- We also saw that mothers were able to stay with their babies in the NICU, prior to going home. Parents and children were also visited by community teams, to enable the transition from inpatient services into the community to be seamless and supportive.
- The majority of parents and children we spoke with told us they received good communication, and had an understanding of the plan of care. Only one parent expressed dissatisfaction with their involvement. They told us "I wish the doctors would talk to us directly instead of talking around the corner".

Emotional support

- We spoke with a chaplain who felt there was a good relationship with the paediatric and neonatal services. They told us emotional and spiritual support was available to families as required.
- There was not a psychologist employed by the trust. Staff explained that patients were referred to external psychologist services, if required and appropriate to do so.

Are services for children and young people responsive?

Good

The staff we spoke with had a good understanding of the population who used the service, and were all able to explain with confidence the requirements of the people they cared for.

Care and treatment plans were individualised. Needs were assessed, and the care plans reflected the needs well. The staff we spoke with had a good understanding of the needs of the children and babies they cared for. Advanced neonatal nurse practitioners provided a responsive service to babies and their families, with NICU also offering a valuable support to babies transferred home with oxygen and feeding support.

Service planning and delivery to meet the needs of local people

- The staff we spoke with had a good understanding of the population who used the service, and were all able to explain with confidence the requirements of the people they cared for.
- Staff had access to interpreters, and could access the Language Line service. The majority of staff told us that they used this service when required, and found it useful. The staff were able to explain the most common languages used in the area. We also saw a variety of information leaflets in departments. Staff told us they were easily accessible in different languages.

Access and flow

- None of the staff or patients and their families we spoke with indicated concerns with the access to the service. We saw that the bed occupancy did not over burden the staff at the time of our inspection; however, the official data on bed occupancy was requested, but not made available to us at the time of our inspection.

Meeting people's individual needs

- Advanced neonatal nurse practitioners provided a responsive service to babies and their families, with NICU also offering a valuable support to babies transferred home with oxygen and feeding support.
- All the notes we reviewed were individualised to the child's needs. There was good evidence of risk assessment of individual needs. For example, we saw a very detailed assessment of nasogastric feeding risks in one care record. Overall, the care plans and records were comprehensive.
- Good care planning was also evident within the NICU, and all the staff we spoke with were aware of the care planning needs and treatment plans of each child. The needs and support of the parents were also documented.
- Advanced neonatal nurse practitioners (AANP) and enhanced nurse practitioners (ENP) were employed,

and supplemented the junior medical rota. This meant that there was senior cover on the majority of day shifts, to ensure that staff had access to support for children with complex needs.

- There were specialist paediatric nurses employed, such as nurses specialising in epilepsy, diabetes and oncology. We spoke with the oncology and diabetic specialist, who explained how specialist multidisciplinary clinics are held on a regular basis. We also identified areas of good practice, such as specialist nurses visiting schools to give support and training. The diabetic specialist nurse also explained how awareness sessions were held for children in restaurants and leisure centres.
- There were good kitchen facilities for parents in the NICU. This meant that parents were able to make drinks and snacks when visiting their babies for long periods of time.
- Each child and family's culture, beliefs and values had been taken into account in the planning and delivery of care. Staff told us about an incident and complaint where a family had been offered food which, because of their cultural beliefs, they were unable to eat. We saw evidence that the complaint had initiated an investigation, and as a result, all children and their families were asked on admission to express their cultural and dietary preferences.

Learning from complaints and concerns

- We found the service had systems in place for learning from experiences, concerns and complaints, and these systems were generally effective in all areas that we inspected.
- The staff shared an example of where a parent had complained about the lack of skills and knowledge for dealing with a particular clinical need. The practice development nurse explained to us how a specialist nurse had been asked to attend the service, and delivered specialist training to staff, with the learning subsequently fed back to the parent.

Are services for children and young people well-led?

Good

There was uncertainty between the staff groups about what the vision for the service was.

Key performance indicators, workforce issues, and learning from incidents and complaints, were discussed at local and trust level.

We saw effective and committed leadership at team and senior clinician level, and staff told us they were generally well supported by their managers.

Vision and strategy for this service

- There was uncertainty between the staff groups about what the vision for the service was. We asked a number of staff, who could not give a clear answer. Staff explained to us how there had been several years of uncertainty, and the trust board had been inconsistent for some time. However, staff also indicated to us that the present board and chief executive had improved the feeling of uncertainty, and staff had access to a weekly chief executive blog.
- A number of staff told us that they felt the trust's emphasis was on the older population, and that the paediatric service was not listened to as much as they would like it to be.

Governance, risk management and

- There was a robust governance framework and reporting structure. We saw from the clinical performance and governance scorecard and risk register that there were clear lines of responsibility and communication. Key performance indicators, workforce issues, and learning from incidents and complaints were discussed at SQaBB and by the clinical governance committee.
- Risks to the delivery of high quality care were identified, analysed, and controls put into place. Key risks and actions were discussed at SQaBB and by the clinical governance committee. However, there were risks evident on the risk register that had been discussed for some time, which had not been resolved at the time of our inspection, such as concerns with staffing levels.

- We found that the service had an effective process in place for carrying out clinical audits. The service contributed to SQaBB and to the clinical governance committee.

Leadership of service

- We saw effective and committed leadership at team and senior clinician level, and staff told us they were generally well supported by their managers. However, nursing staff did not have regular, effective supervision at ward level, and only 87% of staff received an appraisal in 2013/14.

Culture within the service

- Staff told us of their commitment to provide safe and caring services for children and young people. There was an open culture, where staff felt able to report incidents and near misses.
- Most staff we spoke with were positive and passionate about the care and service they provided. One member of staff told us “everyone works as a team and there is good multidisciplinary working".
- The overall sickness rate for the division in 2013/14 was 4.7%, which was over the trust’s target of 3.7%. The staff survey for 2013/14 scored worse than expected in staff experiencing harassment, good communication between senior management and staff, and fairness and effectiveness of procedures for reporting incidents and near misses. However, during our inspection no staff indicated to us that these were issues within the paediatric service.

Public and staff engagement

- There was a comments box visible on the wards. A common concern raised was that of parking fees, when children were inpatients for a length of time. Staff explained to us that because of the comments, parking permits were now issued. This demonstrated that the service listened to parent’s comments and concerns.

Innovation, improvement and sustainability

- There was appropriate monitoring, reporting and learning from incidents. We saw clear and effective management within the service. The main area of concern was the recruitment of new staff, which the trust were aware of, and monitored through the SQaBB and the clinical governance committee.

End of life care

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

Information about the service

Patients requiring end of life care were cared for across the hospital. Shouldham ward had four dedicated palliative care beds. The palliative care team provided support to staff and patients across the hospital.

Over the course of the two day inspection we reviewed information from interviews and discussions with staff as well as listening to patients accounts during the listening event we held in the local community. We visited the chemotherapy suite, the stroke unit, two general medical wards, Shouldham ward, the bereavement centre, the mortuary and the Sacred Space. We spoke with six patients, twelve relatives, 18 members of staff including nurses, doctors, ward clerks, mortuary technicians and staff in the bereavement centre. We observed patient care and we also looked at twelve patient records.

Summary of findings

The palliative care team were stretched and whilst care was in general good the trust is required to make improvements in order that all patients receive appropriate care at the end of their life. All staff received half an hour update as part of their mandatory training on end of life care. Staff did not feel this was sufficient. The palliative care team had been unable to provide bespoke training on end of life care due to staffing pressures in their team. The palliative care team were undergoing a review, but this was taking a long time and had commenced in April 2013. Patient care was seen as a priority, but other important areas such as audit, training and service development had been neglected. There were shortages of medical staff and we found consultants were working on good will and were keeping contact with the ward out of hours and at weekends even when they were not on call.

The trust had withdrawn the use of the Liverpool Care Pathway, but staff were not always clear about what guidance they should have been following. The palliative care team were striving to follow best practice guidance but they were limited to what they could develop. We saw some excellent multidisciplinary working in the hospital and there was access to seven day palliative care services. End of life services were caring. Patients were treated with compassion, dignity and respect. Patients and relatives spoke positively about their care. Patients and relatives felt involved in

End of life care

their care. The mortuary staff were respectful to deceased patients and we saw they were sensitive when preparing for the deceased patient to be visited by their relatives or friends.

Staff understood their responsibilities with regard to reporting incidents. Ward areas and the mortuary were found to be clean and staff were observed to use personal protective equipment and wash their hands between patients. Anticipatory medication was being prescribed for patients at the end of life, however staff felt there were sometimes delays in getting medical staff to alter medication or intravenous fluids out of hours. Do not attempt cardio pulmonary resuscitation records were complete and we found evidence that patients or their relatives had been consulted about these decisions. Where patients did not have capacity to make their own decisions, conversations had taken place with their relatives.

There was emphasis on ensuring that patients were cared for at the end of life in their preferred location, however, an audit demonstrated that not all patients had their preferred place of death recorded. Rapid discharge was made available for patients who wanted to leave hospital to die in a different location. There were some good facilities in the hospital such as the sacred space and the facilities for bereaved relatives in A&E, but wards lacked spaces where staff could have private conversations with patients or relatives. The lack of side rooms in the hospitals wards meant not all patients at the end of life could be nursed in a side room.

Staff across the service reported a lack of engagement with senior management and there was no executive director with the lead for end of life care. There was no strategy for end of life care and a review of the palliative care team had been underway for 18 months and had affected the morale amongst the team. There were limited governance systems in place although some audits had taken place and had brought about some improvements in practice. We did find some examples of good leadership and staff were committed to providing high quality care for patients at the end of life. There was some good work taking place with one of the Clinical Commissioning Groups to improve the planning for end of life care across primary and secondary care for frail elderly people. The aim of this work was to get a full assessment of the patient with all of the relevant specialities involved.

End of life care

Are end of life care services safe?

Good

Staff understood their responsibilities with regard to reporting incidents. Ward areas and the mortuary were found to be clean and staff were observed to use personal protective equipment and wash their hands between patients.

Anticipatory medication was being prescribed for patients at the end of life, however staff felt there were sometimes delays in getting medical staff to alter medication or intravenous fluids out of hours. Do not attempt cardio pulmonary resuscitation records were complete and we found evidence that patients or their relatives had been consulted about these decisions. Where patients did not have capacity to make their own decisions, conversations had taken place with their relatives.

All staff received half an hour update as part of their mandatory training on end of life care. Staff did not feel this was sufficient. The palliative care team had been unable to provide bespoke training on end of life care due to staffing pressures in their team. Nurse staffing levels had been reviewed on Shouldham ward and recruitment was taking place to improve the pressures they had been facing. The palliative care team were undergoing a review, but this was taking a long time and had commenced in April 2013. Patient care was seen as a priority, but other important areas such as audit, training and service development had been neglected. There were shortages of medical staff and we found consultants were working on good will and were keeping contact with the ward out of hours and at weekends even when they were not on call.

Incidents

- There were no patient safety incidents in relation to end of life care that had been reported, however, this could be due to incidents being attributable to the medical directorate as a whole, rather than to end of life care. We have reported on incidents in more detail in the medical care section of this report.
- Data collected prior to our inspection indicated there had been no recently reported "Never Events" within the area of end of life care at the trust. A serious incident known as a Never Event is classified as such because they are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.
- Staff understood their responsibilities with regard to reporting incidents and they knew how to report them.

Cleanliness, infection control and hygiene

- Ward areas and the mortuary were clean. We saw equipment had dated "I am clean stickers" to show when equipment was last cleaned. We saw clinical waste bags were not stored correctly in the mortuary and we raised this at the time of our inspection.
- Domestic staff told us that there were sufficient staff to be able to carry out their job role.
- We observed staff adhering to the hospital's policy for the prevention and control of infection through washing their hands between tasks and using personal protective equipment (PPE) such as gloves and aprons. Staff adhered to the 'bare below elbow' policy.
- Staff spoken with were aware of their roles and responsibilities in regards to infection control.
- One patient told us they always saw staff wearing protective clothing and they washed their hands regularly.

Medicines

- We were told by staff that patients who required end of life care were written up for anticipatory medicines. We looked at medication administration charts and saw it was prescribed.
- The palliative care team gave advice on anticipatory prescribing and checked to ensure it was prescribed appropriately.
- The National Care of the Dying Audit 2012/13 showed that the trust score was worse than the England average for PRN (as required) medication for the five key symptoms that may develop during the dying phase.
- On Shouldham Ward, we were told by staff that there were occasions out of hours when there were delays getting a doctor to the ward to make changes to patient's medication or to prescribe additional IV fluids. Although we did not see any evidence that patients were at risk of harm, there was a risk that patients would not receive medication or intravenous fluids in a timely way. The nurses told us they would often take the patients medication chart to the ward where the doctor

was located to save the doctor time in coming to the ward. Staff were not reporting these delays as incidents, so there was no monitoring of how frequently this was occurring.
- We spoke with the relatives of one patient who was near the end of life and they told us their relative had been kept pain free and comfortable.
- There were plenty of syringe drivers available for use. Staff told us they didn't ever run out of these. Syringe drivers are pumps used to gradually administer medication to a patient and are often used for patients at the end of life.

Records

- We reviewed 10 Do Not Attempt Cardio Pulmonary Resuscitation forms (DNACPR) in the four wards we visited. We found all of these forms had been completed in full. In two patients records we saw a "Ceiling of treatment," form had been introduced. This was to ensure that all treatment options had been considered and discussed with the patient or their relative. The medical director told us this was a new initiative that the trust were just starting to introduce.
- The trust had carried out their own audit of DNARCPR forms in February 2014. The audit took place on five wards and included 32 patient records. The audit contained some good analysis and demonstrated the trust had taken steps to reflect on the findings of the data and review the tool for its future use. An action plan to improve performance had been implemented. Our review of DNACPR records suggested that changes had taken place as we found the standard of record keeping in relation to DNARPCR to be better than the trusts own audit earlier in the year.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw evidence that DNACPR discussion had taken place with patients' families when they lacked capacity to make decisions.
- We spoke with a relative of a patient who was near the end of their life and who didn't have capacity to make decisions about their care. They told us the doctors had discussions with them about their relatives care and asked them about their wishes for their relative and what they thought they would have wanted. The decisions were made with them and the doctors and they felt they had been kept informed.
- Staff generally knew about mental capacity and the reasons why it was important to assess if a patient had capacity to make decisions about their care. We saw patient's capacity assessments were included in the nursing assessment documentation. The palliative care team told us they supported ward staff in issues relating to capacity and consent.
- We did not see any patients who were subject to deprivation of liberty safeguards (DoLS) during our inspection. We did not find any patients who we thought should have been referred for a DoLS assessment.
- There was a thorough approach to writing 'do not attempt cardio pulmonary resuscitation' (DNACPR) protocols in the children's and young people's service, which involved the symptom management team from the hospice services.

Safeguarding

- The trust had a lead nurse for both children's and adult safeguarding. We saw information displayed about these staff in the clinical areas we visited.
- We looked at the records on one of the wards we visited and saw safeguarding concerns had been dealt with appropriately and sensitively. There was good evidence that the multi-disciplinary team had been involved and the patient's wishes had been taken into account. Staff on this ward demonstrated a good understanding of safeguarding adult issues.

Mandatory training

- The specialist palliative care team told us they provided half an hour of training on the trusts mandatory training days. They covered a scenario about end of life care and asked staff to reflect on what they would do in the situation presented. The palliative care team told us they would have liked more than a half hour slot as they were limited to what they could deliver. The palliative care team also felt the staff on the wards needed more training on improving communication skills with patients and relatives to increase their confidence in having discussions about end of life care. We did find some evidence that patients did not have conversations about advance care planning. This meant there was a risk patients were not given the opportunity to have conversations with staff about their end of life wishes whilst they had the capacity to do so.
- Staff on the four ward areas we visited told us they would value more training on end of life care.

End of life care

- The palliative acre team told us they used to provide additional training for medical staff and provided study days for nursing staff. This had been severely restricted for several months due to staffing shortages and pressures within the palliative care team.

Assessing and responding to patient risk

- The wards we visited used a recognised early warning tool to identify any patients who were deteriorating. The documentation told the staff what to do when the scores increased.
- Specialist support was available from the palliative care team and covered 24 hours a day, seven days a week.
- The nurses on Shouldham Ward told us they could always get advice from a palliative care doctor out of hours as there was a regional palliative care doctor rota in place.

Nursing staffing

- Ideal and actual staffing numbers were displayed on the ward areas. Staff told us they normally had enough staff and that any gaps were filled with agency staff. Staff in the mortuary told us there were sufficient staff available.
- The trust had a palliative care team who also provided care to patients in the community. The team provided an end of life care service and predominantly gave advice.
- The palliative care team had been subject to a review which had been ongoing since April 2013. The review had still not been completed. There were 8.63 whole time equivalent nurses for the service but one full time nurse had been off work for some time. No administrative support was provided for the team. The palliative care team did not feel there were sufficient staff to provide an adequate service across the hospital and into the community. Patient care was seen as a priority, but other important areas such as audit, training and service development had been neglected. For example, work to implement the Gold Standard Framework had not been developed. One member of staff on a general medical ward told us it could sometimes be two to three days before the palliative care team could respond to a referral. Data on the length of time taken to respond to referrals for the palliative care team was not collated so we were unable to clarify if there were any delays.
- Nursing staffing levels on Shouldham ward had been increased and there were always three registered nurses on duty during the day and two at night. Registered nurses on Shouldham ward provided cover for the palliative care advice line for patients out of hours. This service allowed patients to call and speak to a nurse if they were experiencing any problems. The ward sister told us that the calls to the advice line could sometimes take a nurse away from the ward for long periods of time.
- The lead palliative care nurse shared the ward manager responsibilities which amounted to working on Shouldham ward three days a week. In addition to this, the lead nurse participated in the senior nurse on call rota. This meant the lead nurse was taken away from her role as a specialist palliative care nurse for more than 50% of her working week.
- There had been significant nursing vacancies and maternity leave on Shouldham ward. Recruitment was underway to fill these posts.
- The nursing handover on Shouldham ward was well run and relevant information was given for each patient.

Medical staffing

- The palliative care team had one locum consultant in palliative care. In addition there was a part time middle grade doctor. It was felt the medical cover for the palliative care team was insufficient and a review was required to assess the level of medical staffing that was required to provide a good quality end of life service.
- Staff on Shouldham ward told us there could be delays getting junior on call medical staff to attend the ward out of hours. This was due to the workloads of the doctors across the trust. However, the nursing staff on Shouldham ward told us the consultant medical staff were very supportive and would come in out of hours even if they were not on call. The nursing staff told us, the consultants for the oncology or palliative care patients ring in at weekends to check on their patient's even when they are not on call.

Major incident awareness and training

- The mortuary technicians told us they had a contingency plan in the event that the mortuary became full. There were additional fridges within the mortuary that could be used.
- The mortuary technicians were not aware of the recent alert issued by the World Health Organisation in relation to Ebola.

Are end of life care services effective?

End of life care

Good

Despite that limited availability of the palliative care team, patients received effective end of life care services. The palliative care team were available on site during working hours and an on call system had been implemented to provide out of hours support. The trust had withdrawn the use of the Liverpool Care Pathway, but the palliative care team were striving to follow best practice guidance but they were limited to what they could develop. Nursing staff on the wards provided good care with limited knowledge and pathway tools to assist them. Patients received adequate pain relief and anticipatory prescribing of pain relief was taking place. We were not clear if patients were receiving mouth care and we did not find evidence that staff were recording if mouth care had been given in patients records. There was limited monitoring of patient outcomes in relation to end of life care taking place across the trust.

We saw some excellent multidisciplinary working in the hospital and there was access to seven day palliative care services.

Evidence-based care and treatment

- The trust had withdrawn the use of the Liverpool Care Pathway (LCP). We spoke with two nurses on medical wards who told us they were unsure of what guidance they be following since the LCP was no longer in use. The palliative care team told us they were striving to follow the Department of Health's end of life care strategy and quality markers and the NICE Quality Standard QS13, but this was difficult because of their capacity issues and they had stopped their education programme. They recognised they needed to do more development work on this across the trust. This meant that there was no clear guidance in place for staff to follow.
- Staff were aware of patients who required end of life care on the wards we visited.
- The specialist palliative care team provided clinical care to patients who were at the end of life on the wards, supporting and empowering staff, patients and carers.
- The trust had not developed the service in line with recognised framework, although the lead palliative care nurse said this would be a priority when the capacity in the team improved.

Pain relief

- Medical and nursing staff could contact the specialist palliative care team for advice about appropriate pain relief if required. The palliative care team did not think all staff used their advice as much as they could and they needed to promote the service they provided.
- Appropriate medication was available in the ward areas, and there were examples that anticipatory prescribing was being managed.
- Patients on the ward areas told us that pain relief was given as needed. We did not observe patients to be in pain during our inspection.

Nutrition and hydration

- On the four wards we visited, we did not see mouth care equipment in use. We spoke with two nurses on one of the medical wards about mouth care and they told us they would give it if it was needed. We asked the relatives of a patient who was near the end of life if they had seen their relative receive any mouth care. They had not seen this taking place and we could not find any record of mouth care being delivered to this patient in their nursing records. We looked at the nursing documentation and could not find a chart which prompted the nurse to record if mouth care had been given. This meant we were not assured that patients were receiving mouth care.

Patient outcomes

- The trust participated in the National care of the Dying Audit (NCDAH) 2012/13. The scores for the trust were variable with the trust scoring better than the England average in some areas. Following our discussions with the palliative care team, we concluded the audit findings had the potential to be outdated.
- A quality audit of patients preferred place of death had been undertaken. 501 patients were included in the audit but 49% of these had no preferred place of death recorded in their notes. Of those that did, 85% died at their preferred place and 46% of patient died at home. The rates had improved since the last audit in 2011.

Competent staff

- Nursing staff we spoke with told us they had received an appraisal within the last year. On Shoulden ward, staff told us supervision took place but was not regular due to the staffing shortages they had experienced.
- The palliative care team had not been able to deliver training on end of life care due to capacity issues, for

example they told us they used to offer training to junior doctors on breaking bad news and communication skills, but they had stopped doing this and were unsure if the junior doctors received this training from anywhere else.
- On Shoulden ward there were a number of new nurses who did not have experience of working with patients at the end of life. The palliative care team did not have the capacity to provide these new staff with as much support and training as they would have liked.
- Each ward had a palliative care link nurse, the palliative care lead nurse told us more needed to be done to further enhance the role of the link nurse and provide training and support for them.
- The lead nurse for palliative care told us nursing and medical staff on the wards needed more training and support with communication skills so they were more confident in having discussions with patients about their end of life care.

Multidisciplinary working

- There was clear evidence of multidisciplinary team (MDT) working on the ward. The multidisciplinary working on the stroke ward was exceptionally good.
- The specialist palliative care team worked in a collaborative and multidisciplinary manner. The service included spiritual support from the chaplaincy team and bereavement support from the bereavement centre. There were regular MDT meetings to discuss patients care.
- There were good links with the palliative care services within the community and the palliative care team followed patients into the community. The nurses described they had good relationships with the local hospice, the hospice at home service and the community healthcare trust.
- We did not see there was any electronic palliative care co-ordination system in use.

Seven-day services

- The palliative care team were available Monday to Friday from 9:00am to 5:00pm. A member of the palliative care team was also available over the weekend. The team also provided out of hours support by telephone.
- The chaplaincy service provided 24 hour, on call support for patients and relatives.
- There was a medical presence on the wards seven days a week. The hospital was part of a network with other hospitals across East Anglia and there was always a palliative care consultant who the staff could contact for advice.
- The mortuary staff were on call 24 hours a day

Are end of life care services caring?

Good

End of life services were caring. Patients were treated with compassion, dignity and respect. Patients and relatives spoke positively about their care. Advanced care planning was not taking place with patients who were in the last year of life and only around 10% of patients were admitted with advanced care plans in place. We saw evidence that the palliative care team were having discussions with patients about their end of life care choices when admitted to the hospital. Patients and relatives felt involved in their care.

The mortuary staff were respectful to deceased patients and we saw they were sensitive when preparing for the deceased patient to be visited by their relatives or friends.

Compassionate care

- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. Curtains were drawn and privacy was respected when staff were supporting patients with personal care. The patients we spoke with told us were positive about their care. Ward staff were aware of patients who were receiving end of life care. They were able to discuss their needs and the support that they required. They demonstrated compassion and respect.
- Relatives all spoke positively about the care and treatment their relatives received. Normal visiting times were waived for relatives of patients who were at the end of their life.
- We spoke with a relative of a patient who was receiving end of life care and they told us they were very impressed by the level of care their relative had received. They told us, “Nothing has been too much trouble for them (the nurses).”
- We saw day centre care in the oncology ward (Shouldham), where volunteers were available to talk to patients and give complimentary therapies, such as hand and shoulder massages.

End of life care

- The trust took part the 2012/13 National Care of the Dying Audit. The trust scored slightly better than the England average for the indicator, health professional's discussions with both the patients and their relatives/ friends regarding their recognition the patient is dying.
- During our inspection we visited the mortuary and spoke with the mortuary technicians. On discussion staff were able to demonstrate compassion, respect and an understanding of preserving the dignity and privacy of patients following death. One of the mortuary staff said, "We are proud of what we do here and we treat the deceased as if they were our relatives." We observed the mortuary staff preparing for a visit by a relative of a deceased patient. They did this is a sensitive manner.
- We also visited the bereavement office and spoke with the chaplaincy staff. They also showed compassion and respect for patients.

Patient understanding and involvement

- We spoke with two patients who both felt their care had been good and staff were caring. It was clear however from our conversations with them that no specific advance care planning had taken place in order to elicit their wishes about their care when they reached the end of life had taken place. The palliative care consultant told us less than 10% of patients were admitted to the hospital with an advance care plan in place. This was an area that the whole health community needed to address.
- Patients we spoke with told us that they felt involved in their care. Relatives we spoke with told us they had been involved in decision making as necessary.
- We saw evidence that the palliative care team had discussions with patients, and where relevant, with their relatives about where they wanted to receive care at the end of life. The palliative care team told us they thought staff on the general wards needed more training in communication skills to enable then to have more confidence in having discussions with patients about end of life issues.

Emotional support

- Throughout our inspection we saw that staff were responsive to the emotional needs of patients and their visitors. Staff told us about examples where staff had considered the needs of relatives. A gentleman had been allowed stayed on the ward with his wife for five days so he could be with his wife. The staff provided him with a reclining chair and all of his meals.
- During our inspection we visited the bereavement centre. The bereavement support officer provided relatives with the medical certificate of cause of death. They signposted relatives to the "Friends in Bereavement Service," which was a bereavement counselling service. This was based on whether they thought the relative required some support and was more reactive rather than proactive. There did not appear to be links with the bereavement support officer and the palliative care team.
- Chaplaincy staff were visible within the hospital and staff within the ward areas told us they could access religious representatives from all denominations as required. Chaplains attended the weekly board round as part of the multi-disciplinary palliative care team. Some staff told us they felt the chaplains could be more visible on the wards.
- We saw that emotional support was also offered following death by staff from the mortuary as families come to visit their loved ones in the chapel of rest.

Are end of life care services responsive?

Requires Improvement

End of life services were not responsive to the needs of patients. Patients were often moved from the palliative care ward to medical wards when a further admission was necessary. This meant that continuity of care and specialised care was lost. However the palliative care team were providing a seven day a week service and out of hours support was also available through a telephone advice line. Nursing staff were aware of the importance placed on the preferred place of death of patients but this was not always documented. Rapid discharge was made available for patients who wanted to leave hospital to die in a different location.

There were some good facilities in the hospital such as the sacred space and the facilities for bereaved relatives in A&E, but wards lacked spaces where staff could have private conversations with patients or relatives. The lack of side rooms in the hospitals wards meant not all patients at the end of life could be nursed in a side room.

Information about complaints was displayed and patients knew how to raise any concerns.

End of life care

Service planning and delivery to meet the needs of local people

- The palliative care team were available seven days a week from 9:00am to 5:00pm. The team also provided out of hours support by telephone. The palliative care team told us they aimed to see patients within 24 hours of referral.
- The specialist palliative care team were aware of the cultural and religious beliefs of the multicultural society. The chaplaincy worked closely with local representatives of various denominations.

Access and flow

- Patients requiring specialist palliative support were referred by the ward teams. The locum palliative care consultant received referrals from other consultants.
- We saw that multidisciplinary team board rounds were undertaken on each of the ward areas every morning where plans relating to appropriate discharge were discussed.
- We saw a patient who was at the end of life. They had been moved from the ward in the hospital that specialised in providing palliative care to a general medical ward. Ward staff were not clear why this patient had been transferred from a specialist ward to a general ward when they were at the end of their life.
- Staff on the palliative care ward told us that due to pressure on beds they often had to move patients. The palliative care team would follow the patients around the hospital to ensure their end of life care needs were being planned appropriately.

Meeting people's individual needs

- Where possible side rooms were prioritised for patients at the end of their life but most of the wards had a limited number of side rooms and these were often used for patients who required barrier nursing. We found in the A&E department/ emergency department there was a room for bereaved relatives with a viewing facility; we noted this as good practice.
- Emphasis had been placed on ensuring care was carried out in the patients preferred place. The specialist palliative care team had introduced a rapid discharge home scheme for people who had identified a wish to be cared for in their own home. We saw evidence of one patient whose discharged was being fast tracked to ensure they went to their preferred place as soon as possible. The trust interpreted rapid as meaning a quick discharge within a few hours.
- A quality audit of patients preferred place of death had been undertaken. 501 patients were included in the audit but 49% of these had no preferred place of death recorded in their notes. Of those that did, 85% died at their preferred place and 46% of patient died at home. The rates had improved since the last audit in 2011. Although these rates show the trust was helping patients to die in their preferred place, a significant number of patients were not being asked about where they wanted to die. This meant there was a risk the service was not meeting people's individual needs.
- Multifaith chaplaincy was available 24 hours seven days a week. Arrangements had been made with the mortuary and local coroners to ensure where necessary for religious reasons, bodies could be released promptly.
- The hospital had a "Sacred Space," which was a multi faith area for use by staff and patients. We saw this was well used by both staff and patients alike. There were facilities within the sacred space for all different faiths to practise their religious beliefs.
- Interpreters were available where necessary. Staff told us that a telephone service was available or staff working within the hospital would facilitate translation.
- Written information and supplementary leaflets were available to support communication with patients and relatives. Patients and their relatives told us they had access to appropriate information.
- There was a learning disability hospital liaison nurse specialist who was employed to provide support and advice to patients, relatives and staff. The palliative care team told us they would access support from this specialist as required.
- A specialist dementia team was employed across the hospital. Staff had received training in dementia awareness.
- The trust was working with the local Clinical Commissioning Group to provide an improved service to frail elderly people. The trust was about to implement the use of the "Edmonton Fail Scale." to assess the degree of frailty. It included a comprehensive geriatric assessment. We noted this was an area of good practice.
- We saw the wards lacked space to have private consultations with relatives or patients. On Shouldham

ward there was a relative's room. This was very small and would have benefited from enhanced decoration and layout. The room was also used by staff for their breaks as well as a staff meeting room.
- We saw that following a charitable donation, a log cabin was available for relatives to use. This provided excellent facilities which were highly valued by staff and relatives alike.

Learning from complaints and

- We did not speak with any relatives or patients who had complaints about the care they or their relative was receiving.
- Patients we spoke with felt they would know how to complain to the hospital if they needed to.
- Information was available in the hospital to inform patients and relatives about how to make a complaint.
- On Shouldham ward, the ward sister was not aware of any recent complaints that had been received.

Are end of life care services well-led?

Requires Improvement

The end of life service requires improvement in leadership in order that the service continues to improve its responsiveness to the needs of the patient. Staff across the service reported a lack of engagement with senior management and there was no executive director with the lead for end of life care. There was no strategy for end of life care and a review of the palliative care team had been underway for 18 months and had affected the morale amongst the team. The outcome of this review was still unknown at the time of our inspection. The locum palliative care consultant was providing good leadership at a local level. They had the capability to lead but their capacity to deliver the required changes was proving very challenging.

There were limited governance systems in place although some audits had taken place and had brought about some improvements in practice. We did find some examples of good leadership and staff were committed to providing high quality care for patients at the end of life. There was some good work taking place with one of the Clinical Commissioning Groups to improve the planning for end of life care across primary and secondary care for frail elderly people. The aim of this work was to get a full assessment of the patient with all of the relevant specialities involved.

Vision and strategy for this service

- There was no executive director with a lead for end of life care. There was limited engagement with senior management within the service.
- There was no strategy for end of life care, although the new locum palliative care consultant who started in post in March 2014 was very keen to develop one. It was clear the palliative care consultant had a vision for the service but more support for the service was required by the trusts executive leadership team. There was a risk that the trust would not retain the locum palliative care consultant if this was not addressed.
- There had been a review of the palliative care service underway for 18 months. Due to the length of time this review had taken, staff morale had been affected. The palliative care team had been left feeling insecure about their future.
- The locum consultant in palliative care told us there was limited focus on end of life care for non-cancer patients in the hospital.

Governance, risk management and quality measurement

- There limited governance systems were in place for the end of life service, although the locum palliative care consultant had identified this gap and was hoping to address this. This meant there was no ongoing monitoring of complaints, incidents, audits and quality improvement projects that related to the end of life care service within the trust.
- Audits on DNARCPR and preferred place of death had taken place and there was good analysis of the DNACPR audit in order to improve practice.

Leadership of service

- Shouldham ward had undergone some staffing difficulties and had been without a permanent ward leader. We did not find evidence that this had directly affected patient care, but it was clear from our discussions with staff that the ward lacked strong and effective leadership.

End of life care

- The locum palliative care consultant was providing good leadership at a local level. They had the capability to lead but the limited capacity to deliver the required changes was proving very challenging.
- Staff told us the palliative care team were supportive and provided them with help and advice to deliver good care for patients at the end of life but not all of the staff we spoke with were aware of the palliative care team and the fact there was a 24 hour advice line they could contact.
- The palliative care team expressed their frustration that they were not all based in the same location. The staff nurses were based within a large open plan office which did not afford privacy when talking with relatives or patients on the telephone.

Culture within the service

- Staff told us they thought they provided good care and they were proud to work at the hospital.
- The palliative care team, the mortuary staff and the Chaplains were very proud of the difference they made to patients and their relatives and friends.
- Staff worked well together and there was obvious respect not only between specialities but also across disciplines.
- Staff were committed to providing patients at the end of life high quality care.

Public and staff engagement

- The trust took part in the Family and Friends test but the response rate was low and in some cases as low as 17%.
- The Patient Advice and Liaison Service (PALS) was visible and patients and relatives we spoke with knew about the service they provided.
- Patients we spoke with knew how to raise any concerns. We saw some information for patients on how to raise complaints displayed around the hospital.

Innovation, improvement and sustainability

- We found evidence that one of the geriatricians at the trust was working closely with the Clinical Commissioning Group to improve the planning for end of life care across primary and secondary care for frail elderly people. The aim of this work was to get a full assessment of the patient with all of the relevant specialities involved. The palliative care team were members of the East of England Strategic Clinical Network for end of life care.
- The lead palliative care nurse expressed her frustration that due to staffing pressures there had been little service development over the previous months. However the team were engaged in some development, for example four palliative care beds had been made available in a nursing home with a GP practice providing the direct care.
- Some staff were unsure of what guidance they should follow since the withdrawal of the Liverpool Care Pathway. The trust had not provided new guidance for staff to follow.

Outpatients

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Requires improvement
Well-led	Good
Overall	Requires improvement

Information about the service

The outpatients department at the Queen Elizabeth Hospital is split into several distinct areas. The number of patients seen for the most recent year was 295,207. A number of different specialities are catered for, including ophthalmology, dermatology, colorectal, vascular, general medicine and general surgical clinics.

During this inspection, we visited the main department and dermatology. We spoke with staff, and patients and visitors using the service. We observed care and interactions in the department, and reviewed records.

Summary of findings

The outpatient department requires improvement due to concerns around infection control and management of medicines. The eye clinic was poorly signposted, and information was not available in other languages. The staff working in the department were competent and received training as appropriate; however, they were required to manage the clinic and to undertake dressings, some of which were also of a complex nature. This led to a shortage of staff in some clinics. The department was meeting referral to treatment times (RTT).

We saw good examples of staff respecting patients' privacy and dignity, and patients reported good experiences of the department. In most specialities, the department was meeting targets, apart from in elderly medicine, which was below the required target. Extra clinics were difficult to hold, as there was limited space within the department. However, the department was well-led by the manager, who supported their staff, and staff felt that they had an opportunity to develop and enhance their skills.

Outpatients

Are outpatients services safe?

Requires improvement

We found that the department learnt from incidents, that staff were confident in reporting incidents if they occurred, and that learning from incidents was fed back to staff. There was an appropriate skill mix of staff running the department, supported by senior professionals. Staff had completed mandatory training and were aware of their responsibilities and procedures for safeguarding children and adults.

Much of the department was dated, and we found concerns relating to infection control, including dusty equipment and curtains that we could not be sure had been cleaned. Emergency equipment was in place, but there was no risk assessment in place for its use between two different clinic areas, and the senior nurse in the medical assessment unit (MAU) was unaware of an arrangement to use the MAU resuscitation equipment.

We found a medicines cupboard, left open and unattended in a clinic room, which contained a large amount of prescription-only medicines. The majority of the time, notes were kept secure, but on one occasion, we saw notes left open and unattended.

Incidents

- Incidents were reported using the electronic Datix system.
- We saw that when an incident occurred, a full analysis of the issues was recorded, and actions planned to prevent similar incidents. Information we received prior to the inspection indicated that there had been no recent serious incidents in the department.
- In radiology, we saw that a recent incident had been investigated and discussed with staff within the department.
- Staff we spoke with were confident in how to report serious incidents, and they told us there was an open, 'no blame' culture when reporting incidents. We saw from staff meeting minutes that incidents and learning were discussed regularly, and staff were encouraged to engage with the process. Staff were required to sign the meeting minutes to confirm they had been read and understood.

Cleanliness, infection control and hygiene

- We saw that staff washed their hands between patient contacts, and that there was alcohol hand gel available for staff, patients and visitors. We saw staff using personal protective equipment (PPE), such as gloves and aprons, when they were required. Staff were 'bare below the elbows' in line with trust policy and national guidelines.
- We examined the resuscitation equipment, and found it to be visibly dusty. Furthermore, we saw a wall mounted emergency eye care kit that was also dusty.
- Around some staff desks in the department were raised boards to ensure privacy, and these were covered in fabric. We saw that in some cases, the fabric had become noticeably frayed, and posed an infection control risk.
- In some clinic rooms there were fabric curtains to maintain people's dignity. There were also portable privacy screens with a fabric curtain. There was no date affixed to them to say when they had last been cleaned. We spoke with staff in the department, who told us that the curtains were cleaned regularly, but they were unable to tell us when this had last been done.

Environment and equipment

- The environment within the outpatients department was variable from one clinic area to another. Some areas had been refurbished and were fit for purpose. The majority of the department had not been recently refurbished, and required improvement.
- Whilst we saw that patients were usually able to find a seat whilst they were waiting, some of the areas were cramped, and we saw on two occasions that manoeuvring wheelchairs past other patients and seating was not easy.
- Equipment within the department had been checked and serviced as appropriate, and was clean.
- The department had a 'grab bag' which contained resuscitation equipment. This was checked daily and found to be correct.
- The outpatients department held clinics in different parts of the hospital. We were told that the resuscitation equipment was portable, and could be used at the other clinic, which was further down a public corridor. We asked if there was a risk assessment for using the resuscitation equipment between these clinic areas, and were told there was not one.

Outpatients

- Staff told us that if there was an emergency at the other clinic area, then they would use the resuscitation equipment from the Medical Assessment Unit (MAU). We spoke with the manager of the MAU, who told us that they were not aware of this arrangement. We could not be sure that there were adequate arrangements for managing emergencies in the outpatients department.

Medicines

- We examined a sample of medicines, and found them to be in date and stored at the correct temperature.
- We spoke with one patient who had been given a new medication. They told us that the medicine had been explained to them, and they were aware of potential side effects.
- Medicines were not always stored correctly. We saw that one clinic room door had been left open and did not appear to be in use. There was a cupboard on the wall with the door slightly open. Inside the cupboard was a large quantity of prescription-only medicines, including eye drops. We waited outside the room for ten minutes, but no staff locked either the cupboard or the clinic room.

Records

- Staff told us that it was unusual for them not to have notes available when patients were seen in clinic.
- Notes for patients attending clinic were kept covered, in trolleys and on reception desks, so as to maintain confidentiality.
- We saw that one set of notes had been left open and unattended in a clinic room.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

- Patients signed consent forms prior to a procedure taking place. We saw that they were given information to make a decision, and the risks and benefits were made clear to them.
- We saw that staff had received training in the Mental Capacity Act. Two staff we spoke with were able to tell us their responsibilities under the Act.

Safeguarding

- Staff had completed training for safeguarding adults and children. Staff we spoke with were confident in reporting safeguarding concerns, and were aware of how to escalate concerns to a designated safeguarding team.

Mandatory training

- We looked at staff mandatory training records. We saw that a large majority of staff were up to date with their mandatory training. Training was completed, both online and face-to-face, and covered areas such as safeguarding, moving and handling, resuscitation, infection control, and conflict resolution.

Nursing staffing

- The department was staffed by a mix of registered nurses and health care assistants. We saw that some staff had undertaken further training to enable them to provide additional care.
- We saw that the department had undertaken a review of the hours required to provide the service, and had recently recruited additional health care assistants.
- Additional staffing was provided by 'bank' staff. Bank staff had received mandatory induction and training, and were orientated to the department when starting work.

Medical staffing

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- Additional staffing was provided by 'bank' staff. Bank staff had received mandatory induction and training, and were orientated to the department when starting work.

Medical staffing

- Medical staffing was provided by the specialty running the clinics in outpatients. Medical staff undertaking the outpatients clinics were of mixed grades, including consultants and staff grades, and also junior doctors. One member of staff we spoke with told us that they felt knowledgeable to see the patients in the clinic, and had support from senior staff.
- We were told that retaining some medical staff was difficult, and some specialities, such as ophthalmology, were required to use locum staff to see patients in clinic.
- Staff we spoke with told us that they were aware of the additional support which locum staff may require when working in the department.

Outpatients

Major incident awareness and training

- There was a major incident policy, and staff were aware of their role in the event of a major incident.

Are outpatients services effective?

Not sufficient evidence to rate

Evidence-based care and treatment was practised in the department, and we saw NICE guidance in use in dermatology and ophthalmology. The trust had a high follow-up appointment to new patient appointment ratio.

Staff were competent to carry out their roles, and were supported to undertake further training and develop enhanced skills, and there was evidence of effective multidisciplinary working. Some clinics were being operated over weekends and evenings, to meet referral to treatment time targets, and offer greater choice to patients.

Evidence-based care and treatment

- We saw that the department was operating to local policies and procedures. Staff we spoke with were aware of how these impacted on the care they delivered.
- We saw that national guidance was used, such as NICE guidance in dermatology. Staff we spoke with described how they ensured the care they provided was best practice, and in line with national guidance.

Patient outcomes

- There was some clinical audit carried out in the department. We saw an audit of patients presenting symptoms and their suitability to be seen in a hospital setting.
- Information we received prior to the inspection indicated that the trust had a high follow-up to new patient ratio.
- At the time of our inspection, outpatient letters to GPs for ophthalmology were being sent out in one week.

Competent staff

- We were told that staff had received supervision and appraisals. We viewed the appraisal and training data which supported what we were told. Staff we spoke with confirmed that they had received appraisals in the last year. Minutes from team meetings showed that they were held regularly, and staff were able to contribute to them.
- Some staff, such as specialist nurses, had undertaken nationally-recognised courses to perform advanced clinical skills.
- Health care assistants were supported to undertake national vocational qualifications (NVQs). Staff that had achieved this qualification could then take on additional skills, such as phlebotomy.
- Staff with professional qualifications were supported to continue professional development and maintain their registration.

Multidisciplinary working

- There was evidence of multidisciplinary working in the outpatients department.
- Specialist nurses ran clinics for some specialities, such as ophthalmology and dermatology. We spoke with three specialist nurses, who described how their clinics fitted in to treatment pathways.
- We saw that patients were regularly referred to community-based services, such as community nurses and GP services.

Seven-day services

- The outpatients department was running evening and weekend clinics for some specialties, such as ophthalmology. We were told that this was to ensure that referral to treatment times (RTT) were met, and to offer patients a choice for their appointments.

Are outpatients services caring?

Good

We saw numerous examples of patients being treated with dignity and respect, and given compassionate care. Clinic room doors were kept closed, and staff knocked before entering clinic rooms, so as not to disturb patients. Patients told us that doctors, nurses and allied health professionals answered their questions, and kept them informed of their care and treatment. We saw that patients were given information about their treatment, gave consent prior to any treatment, and were also given the name and contact details of a professional involved with their care.

Outpatients

Compassionate care

- During our inspection, we saw patients being treated with compassion, dignity and respect. We saw staff using humour to build rapport with patients, and staff were welcoming to patients when they entered the department.
- Curtains were drawn inside clinic rooms to maintain people's privacy and dignity. Staff told us that if patients were unwell, wherever possible, they were moved into a clinic room quickly. We saw staff knocking on doors before entering clinic rooms. In the radiology department, we saw that there were changing facilities available that maintained people's dignity.
- We saw that there were suggestion boxes available for feedback from patients and visitors, and we saw evidence of changes to the department layout in response to feedback from patients.

Patient understanding and involvement

- We spoke with patients in the department, who told us that they had been kept fully informed of their care and the plans for future treatment. They told us that the healthcare professional they had seen had answered their questions, and given them enough time to discuss their care.
- Patients had signed consent forms for procedures. Consent forms clearly described the risks and benefits of the procedure. The patient's notes demonstrated that people had been given options about their care.
- Information was available for patients to take away about their condition, or any procedure they were to have, and what to expect afterwards.

Emotional support

- Staff told us how they supported patients, their relatives and carers, during their stay in the department, which emphasised a collaborative approach to care.
- Where patients consented, staff in the department ensured that their relatives were involved with the consultation.
- Clinical nurse specialists were a first point of contact for many patients using the department, which ensured patients were able to speak to someone about their care should they need to.
- We were told that it was possible to refer some patients for counselling, if that was required.

Are outpatients services responsive?

Requires improvement

The outpatient department required improvements to make its services responsive to meet the needs of all patients. The department used Language Line for interpretation services, but there was limited written information in languages other than English in the department. We were concerned that arrangements in the ophthalmology clinic were not responsive for people with restricted eyesight, including poor or absent signage. Due to the nature and age of the building, it was not always easy to navigate the department for people with mobility problems or for wheelchair users.

The outpatients department provided additional clinics to ensure patients were seen in a timely manner, although managers told us that it was not always possible to see patients at short notice. The trust was meeting most of its referral to treatment time targets, and waits for diagnostic tests were below the national average. The 'did not attend' (DNA) rate for appointments was below the national average, and the department ran some outreach clinics in other areas. The department was providing one-stop clinics for patients with certain conditions, and completing diagnostic tests in one day, to reduce the need for multiple appointments.

Service planning and delivery to meet the needs of local people

- Additional clinics were provided at weekends and in evenings to ensure patients were seen in a timely way.
- Staff were supported by 'bank' staff when additional resourcing for clinics was required. The department had recently employed additional staff.
- The department managers told us that due to limited clinic rooms, it was not always possible to run additional clinics, particularly at short notice. Therefore, the demand for outpatient services was not always met.

Access and flow

- The trust was meeting almost all of its referral to treatment times (RTT), according to figures for April 2014.
- 100% of patients requiring general surgery, urology and oral surgery were seen within target times, as were 97.7% of trauma and orthopaedic patients.

- However, only 86.7% of patients waiting for treatment from elderly care medicine were seen within the target time.
- Weekend and evening clinics were being provided to meet RTT, and to offer patients a greater choice of appointments.
- Staff we spoke with told us that it was common to overbook clinics, particularly eye clinics. We checked some clinic lists at random, and found them to have either the correct number of patients, or an additional two or three patients. Clinic staff told us that because some people did not attend appointments, the clinic would end up not being over booked.
- We spoke with two staff, who told us that appointment times were short, and only included the time to see the primary professional. Following the consultation, some patients required complex dressings to be applied to wounds; staff were given no additional time to do this, and were also expected to run the clinic.
- The DNA rate had been consistently below the national average, but we were aware that it had been above the national average in autumn 2013. Staff told us that patients received a phone call prior to their appointment to remind them of the time.
- Information we considered prior to the inspection, showed that waiting times for diagnostic tests were below the national average.
- Some outreach clinics in ophthalmology were provided in other parts of the county, to enable easier access for patients.

Meeting people's individual needs

- The department used Language Line as an interpretation service in the department, as and when it was required. Staff we spoke with told us that they also made use of staff who spoke other languages, with the patients consent.
- There was limited information displayed, or in leaflet form, for people who spoke languages other than English.
- Staff told us of a situation where a patient was too upset to attend the department, so health care staff conducted the consultation in a different place, to ensure the patients' needs were met.
- We were told that the eye department had a dedicated entrance approximately halfway through the department. We found that the entrance opened onto a vehicle thoroughfare and parking area. The sign above the entrance said it was for 'rehabilitation' and did not say eye clinic. Whilst there were zebra crossings at the entrance, there were no raised 'bumps' to indicate to people with limited vision that they were approaching a road. Although there were some black arrows on a yellow background to indicate the way to eye clinic, signage was otherwise small, and there were no additional ways of communicating used, such as sound or Braille.
- The department had limited space, due to the age of the building, and how seating was arranged. We saw, on two occasions, people in wheelchairs struggle to manage to navigate through the busy department, due to a lack of space.
- A large room with a bed was available for consultations, for patients who required the use of a hoist for transfer purposes.
- Where clinics were running late, we saw staff keeping patients informed of the delay.

Learning from complaints and concerns

- Staff we spoke with were aware of the local complaints procedure, and were confident in dealing with complaints if they arose.
- Information about the Patient Advice and Liaison Service (PALS), and how to make a complaint, were displayed and clearly visible in the department. Suggestion boxes were also used in the department.
- Minutes from staff meetings showed that issues such as complaints or concerns were discussed regularly, and any changes to practice were highlighted.

Are outpatients services well-led?

Good

The manager of the department had a vision for the future of the service. We saw that the service completed audits, and that they had visited other services to develop ideas for service improvement. Staff told us that management and senior staff were visible and approachable.

Staff told us that they had received appraisals, and we saw evidence of this; they also told us that communication channels with management were good: both contradictory to the last NHS staff survey. We saw that the department was increasing the number of one-stop clinics, and supporting staff to extend their skills. Whilst the

department was meeting RTT, due to the limited space and dated environment further innovation would be challenging. Staff told us that they felt that the outpatients department had been neglected for some time.

Vision and strategy for this service

- The department manager demonstrated a vision for the future of the service, and was aware of the challenges it faced. The managers explained how they had recently 'change managed' the department, to enable staff to work across clinic areas, and provide a greater flexibility in service provision. They described this process and how they had supported staff through a difficult time.

Governance, risk management and quality measurement

- The unit leadership, both nursing and medical, had completed audits designed to measure the quality of the service.
- Staff told us that they had been on a visit to Moorfields Eye Hospital in London, to see what they could learn from that service, and had brought back ideas for service improvement, including the need for diagnostics completed on the day of the clinic appointment.
- We saw that governance arrangements and risk management were discussed regularly with staff through staff meetings. Complaints and incidents were discussed with staff at department meetings.

Culture within the service

- Staff told us that the manager of the service, and senior medical staff, were visible and approachable in the department. The nurse in charge of the department wore identification to highlight their presence to staff and visitors.
- Staff told us that the board were visible, and they had read the regular chief executives blog.
- The last NHS staff survey showed that the trust scored below the national average for communication between managers and staff. Staff in the department, however, told us that they had good communication channels with their immediate manager. The last staff survey also reported the trust as scoring worse than average for bullying and harassment, but no staff we spoke with voiced these concerns.
- The NHS staff survey showed that the trust scored more poorly than the national average for staff receiving appraisals. However, staff told us that they received appraisals and team meetings, as well as being supported to develop their role, and undertake further education and training.
- The culture clearly supported staff in raising incidents or concerns. The unit was open and transparent about the incident reporting, and staff we spoke with said they felt able to raise concerns.
- Staff we spoke with were positive about the quality of care they provided, the future of the service, and spoke very highly of the team they worked in.

Innovation, improvement and sustainability

- The department was increasing the number of one-stop clinics in different medical specialities, including dermatology and ophthalmology. The department was also increasing the number of investigations done in a single day, to reduce the need for patients to attend multiple appointments.
- Additional skills for healthcare assistants, such as phlebotomy, meant that more could be done for patients within the department.
- Senior nursing staff in the department told us that they were scheduled to undertake a leadership and management course this year.
- The department appeared sustainable, as it was meeting its RTT, and providing clinics at weekends and evenings. However, the limited space available, and the dated nature of the department, meant that developing services further would be a challenge. Staff told us that they felt the outpatients department had been neglected for some time.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Ensure that resuscitation support, equipment and training is consistent throughout the trust, and compliance with Resuscitation Council guidance is achieved. We found several examples of different equipment on resuscitation trolleys, lack of training and audit especially in A&E and outpatients.
- Ensure that the management of medicines, including storage and recording of temperatures, is done in accordance with national guidelines. We found unlocked medicines storage in outpatients and A&E and medical fridge temperatures not being recorded in medicine and surgery.
- Ensure that patients are protected from the risks associated with the unsafe use and management of medicines, by means of ensuring that appropriate arrangements for the recording and use of medicines are in place. Documentation of the administration of medicines was poor in medicine.
- Review and improve medical staffing levels across the medicine directorate to ensure the safety of patients through education and training.
- Embed skill mix assessments for nursing staff to ensure that skill mix is appropriate and ensures the safety of patients across the hospital but especially in A&E.
- Review nursing staffing levels in both the neonatal and the paediatric unit to ensure that they meet patient acuity and dependency.
- Improve the environment in the emergency department, including paediatric A&E, outpatients and the mortuary to ensure the safety and treatment of patients.
- Improve access to training; both mandatory and 'required to undertake the role' to ensure that staff have the knowledge to care for patients, for example those at the end of their life.
- The trust must review the elective surgery cancellation rates and review the elective surgery service demand.
- Review medical leadership for elective & emergency surgery to ensure common patient centred aims and objectives are evident
- The trust must review and improve cancellation rates within outpatients.
- The trust must ensure that patients are protected from infections by appropriate infection prevention and control practices, especially within the outpatients department.
- The trust must ensure that there are sufficient numbers of staff on duty, who are trained to restrain patients.
- The trust should ensure that an executive director is appointed to champion the end of life services as directed by Norman Lamb MP in his letter to NHS chief executives.

Action the hospital SHOULD take to improve

- Ensure that all staff work together effectively to enhance the experience of the patients, ensuring effective communication at all levels.
- Ensure that equipment storage, within A&E resuscitation areas, is improved.
- Ensure that the environment and storage of equipment in the neonatal unit is better organised.
- Review the equipment used to transport the deceased from the wards to the mortuary, to ensure that it respects people's privacy and dignity.
- Ensure that there are sufficient numbers of staff who are CBRN trained. (CBRN refers to chemical, biological, radiological and nuclear equipment and policies.)
- Ensure that plans to strategically move over to the national early warning score (NEWS) system are agreed and implemented. (The NEWS system relates to the management of deteriorating patients.)
- Ensure that patients are discharged in a timely manner across all wards and, in particular, at the end of their life.
- The trust should review the availability of hydration on Pentney, Oxborough and Necton Wards.