

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	
Urgent and emergency services	Good	
Medical care	Good	
Surgery	Good	
Maternity and gynaecology	Requires improvement	
Services for children and young people	Good	
End of life care	Requires improvement	

Letter from the Chief Inspector of Hospitals

The Care Quality Commission (CQC) carried out a scheduled focused inspection at The Queen Elizabeth Hospital Kings Lynn between the 9 and 11 June 2015. The trust had been placed into special measures in October 2013 due to serious failings and had undergone a full comprehensive inspection in July 2014 where we rated the trust as requires improvement. We carried out the focused inspection in 2015 to review services that had been previously rated as requires improvement or inadequate and to consider the current status of the trust in relation to special measures. Critical care services had been previously rated as good throughout and therefore were not re-inspected.

The trust had two outstanding warning notices in relation to safeguarding (safe and ethical restraint) and medicines management which were reviewed as part of this inspection. We judged that the trust was now meeting the requirements under the regulations and therefore we have removed the warning notices.

Our key findings were as follows:

- In all areas staff were kind, caring and compassionate towards patients.
- Overall the trust leadership is strong and cohesive with a clear vision and strategy, the exceptions to this being some local leadership issues within maternity and end of life services.
- There is good direction and leadership from the chief executive which resonates down through the leadership team.
- There is good communication throughout the organisation and the morale and culture of the organisation has improved since our comprehensive inspection in 2014.
- Increased stability of the board has improved the pace of change at the trust and the confidence in the ability to drive improvements throughout the trust.
- Significant improvements had been made throughout many specialties including the emergency department, medicine and surgery.
- Evidence was not consistently recorded in the emergency department due to the combined use of paper and electronic systems.
- Patient assessments and records were not consistent or updated to reflect changes in a patient's condition within medicine
- The total number of cancelled operations remained high however a downward trend was beginning to emerge in the number of cancelled operations alongside an improving performance on patients rebooked within 28 days.
- The previous concerns regarding privacy and dignity for patients within the breast unit remained in place however the service was due to relocate to new premises which would eradicate the issues.
- Patient outcomes were not being reviewed due to a lack of clinical outcome information within the maternity service.
- Nurse staffing was insufficient in both the neonatal and paediatric unit.
- Complaints and significant events were not being appropriately coded for end of life care so information was not being used to improve services
- The hospital used a prescription and medication administration record chart for patients which facilitated the safe administration of medicines. Medicines interventions by a pharmacist were recorded on the prescription charts to help guide staff in the safe administration of medicines.
- Management of medicines had improved across the trust with the exception of some storage concerns within outpatients and storage of intravenous fluids within the emergency department

In summary urgent and emergency care, medical care and surgery which had previously been rated as requires improvement have now been rated as good, alongside critical care and children and young people's services which had been rated as Good in 2014. Maternity and gynaecology services, end of life care services and outpatients services still require improvement.

We saw several areas of outstanding practice including:

- The waiting area for children within the emergency department, whilst small, was designed in an outstanding way which responsive to all children who visit the service.
- The commitment of midwifery staff to develop effective midwifery services for women from the King's Lynn area. Midwifery staff rotated throughout the service to maintain their knowledge and skills.
- Relatives and staff told us the paediatric team were a well organised and effective team who provided a good service for the children and families of the Kings Lynn area.

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

Importantly, the trust must:

- Ensure that medicines are stored securely at all times including those within the outpatients department, and IV fluids in the emergency department.
- Ensure that resuscitation trolleys are checked in accordance with the trust policy and resuscitation council guidelines.
- Ensure that an accurate record of each patients care is recorded.
- Ensure that the staffing is in line with national guidance. Examples include but are not exclusive to: registered children's nurses in the emergency department, patients requiring non-invasive ventilation, paediatric staff on the children's ward, endoscopy medical staffing, midwives in maternity and staffing on the neonatal intensive care unit.
- Ensure that there is a robust governance system to assess monitor and improve the quality of services especially in respect of decontamination of flexible cystoscopies, clinical outcome data within maternity services and the management of ASIs (Appointment Slot Issues) within outpatients.

In addition the trust should:

- Review the clinical pathways especially for fractured neck of femur between the ED and the orthopaedic service and within the maternity and gynaecology services as highlighted in this report.
- Ensure a system of clinical leadership developed for all areas of the maternity service with clarity about the role, responsibilities and reporting relationships. A strategic vision should be developed.
- Should ensure that infection control practices are adhered to at all times in the emergency department.
- The hospital should develop a joint clinical and managerial response to the review carried out by the royal college of obstetricians which provides a clear strategic vision for the service
- Ensure staff training for patients living with dementia is effective in practice, and that staff can recognise the need and complete the patient passport where necessary.
- Ensure the operational management structure is established and known to all staff within each service
- Access to medical staff on call should be improved across obstetrics and gynaecology to ensure patients have timely access to medical advice
- Develop the role of the PAU in response to the needs of the population
- Ensure incidents and complaints relating to end of life care are easily identified and a process is in place to ensure learning is identified and used to influence the development of the service.
- Ensure the cancellation rates and specialty clinic waiting times in the outpatients department are reviewed and improved.

There is no doubt that leadership of the trust is much stronger than in the past. This has helped to drive very considerable improvements in the quality and safety of patient care in a relatively short period of time. Importantly more of the core services are now rated as 'good' than when we inspected in 2014. I am therefore recommending that the trust should now come out of special measures.

Professor Sir Mike Richards Chief Inspector of Hospitals

Our judgements about each of the main services

Service

Urgent and emergency services Rating

Good

Significant improvements have been made to the urgent and emergency services provided at the Queen Elizabeth Hospital in Kings Lynn since our last inspection 2014. Services were now effective, caring responsive and well led however still required some improvement in safety. Care bundles were in place and the care provided was in line with national guidelines and staff were being developed to become specialised in emergency care. Whilst the service was not always delivering against the four hour target or ambulance handover times they were one of the top performers in the East of England and recovered well from times of peak capacity and demand. The new emergency department for children was very responsive and was built in a way that met the needs of all children including those with complex needs. The board and senior management were engaged in the service and incorporated the ED as part of the trust so the department now felt integrated rather than isolated from other services. The culture of the service had changed significantly since our last inspection with the culture being open and transparent with good working relationships with most services now apparent.

Why have we given this rating?

Whilst the safety of the service had improved further improvements were still required. The service was not able to evidence all the care that was provided to patients because the records system, which was a combination of electronic and paper records, was difficult to navigate and disorganised and meant that completion of records was not good. The resuscitation trolleys had not been checked daily in line with trust policy, IV fluids were not securely stored throughout the department and the hand hygiene of medical staff in the department was noted to be poor.

Medical care

Good

Medical services required improvement in safe because records and risk assessments were not consistently completed and updated in response to a patients changing condition. Nurse staffing had

improved but did not always meet national guidance in relation to specialist respiratory care. There remained ongoing challenges in relation to medical staffing.

Care and treatment was evidence based. We saw that patient pathways and care bundles were underpinned by national and local guidance. Nutrition and hydration was adequately managed and we saw patients had bottled water within reach during our inspection.

Services were planned to meet the needs of local people. Referral to treatment times met national targets and there had been innovative work to reduce length of stays. Admission to the stroke unit (within four hours) was failing to meet the 90% benchmark and audit data for stroke services showed the trust to be performing poorly but we were told this was a data collection issue. There was effective discharge planning and services were responsive to people's needs including named consultants and availability of specialist equipment. Complaints were properly investigated and learning disseminated to staff. The medicine directorate had a clear vision for the service as well as detailed strategic plans for the development of services. There was a robust ward to board governance structure and senior managers had a clear idea of the risks within the directorate. Staff stated there had been a positive shift in culture under the new leadership, staff felt supported and able to raise concerns.

In 2014 surgical services were rated as good for safe, effective and caring and inadequate for responsiveness and requires improvement for well led.

During the inspection in 2015 we reviewed responsiveness and well led aspects of patient care within surgery. There had been considerable improvements, the responsiveness of the service was good and the service was well led. There had been a dedicated focus on improving the efficiency of the service. Whilst cancelled operation total numbers remained high there was a downward trend emerging and an improving performance on patient booked within 28 days

Surgery

Good

Maternity and gynaecology

Requires improvement

Identified specialties for further improvement were trauma and orthopaedics and urology. Timely admission for patients with fractured neck of femur was not consistent and there was no robust system to ensure patients were seen in a timely manner for urology. Feltwell ward (Urology) had no ward manager in position with clinical specialists undertaking dual roles. Staff had raised concerns that this situation was not sustainable and that there was limited risk management and oversight which could become detrimental to patient safety. There was no tracking system in place to record the decontamination of flexible cystoscopes used with urology. The on call consultant cover for Endoscopy required review as there was no formal medical consultant on call rota to cover for emergency gastric bleeds.

Responsive and well led in maternity services required improvement. Many of the issues we identified in maternity services during our last inspection in 2014 report had not improved. Staffing both medical and nursing was a concern, specifically senior medical staffing, and midwifery staffing levels meant staff had to be transferred from other areas of the service to support the central delivery suite (CDS). At times the unit had to close due to insufficient numbers of staff with patients being diverted to other units. Women were not offered the choice between a home birth or a birth in a midwifery led unit. The Trust had developed plans for a midwifery led unit and aimed to have the service in place by September 2015.

Planned elective caesarean sections were delayed on occasions because of theatre and medical staff availability. Patient assessments were not consistently recorded which meant there was a risk that a woman's deteriorating condition may not be escalated appropriately. There were privacy and dignity concerns for women experiencing a miscarriage as they were seen in the main emergency department or the surgical assessment unit before being admitted to a surgical ward. The trust had commissioned a review by the Royal College of Obstetricians to look at the leadership and management of the service. The review

		highlighted the lack of clinical outcome information and the absence of outcome reviews. There was a lack of clinical ownership for clinics, inpatients and theatre lists. The report had been submitted to the trust in April 2015 but it was not clear what the trust's plan was for responding to the recommendations. There had been a change in leadership within the service and a maternity transformation project was in the early stages of development but it was not clear whether consultant medical staff were fully engaged in the work. A strategy for quality improvement across the trust had been developed and strategic objectives had been identified at specialty level however a strategy for maternity services had not been developed.
Services for children and young people	Good	The safety of the children and young people service had improved since our last inspection and despite further improvement required we have rated this service as being good as action had been taken to mitigate the risks we identified. Nurse staffing levels remained an issue and did not comply with national guidelines. The number of beds had been reduced from 23 to 18 on Rudham children's ward to ensure there was adequate staff for the number of beds. The trust planned to increase the beds flexibly in response to demand and there being sufficient staff available. There was only one member of staff available to care for children attending the PAU. A business case had been developed to fund additional staff and opening hours but at the time of our inspection this had not been presented to the board and therefore approval and funding were not definite.
End of life care	Requires improvement	At our previous inspection in 2014 end of life care services were rated as requiring improvement for responsive and well led. In 2015 we found that whilst there had been some improvements there were specific areas where further improvements were still required. These included the development of a plan for specialist consultant input in the event of continued recruitment difficulties. Complaints and significant events were not being appropriately coded for end of life care so information was not being used to improve services. Other areas where information was not

		being used to improve services included mortality meetings that were not focusing on the end of life care journey, the trust was not routinely surveying patients or relatives regarding end of life care and audits to evaluate the quality of care provided were not routinely being carried out.
Outpatients and diagnostic imaging	Requires improvement	 Safety and responsiveness in the outpatient service required improvement. Infection prevention and control had greatly improved since our last inspection in 2014 with a clear audit process in place to ensure that care and treatment was delivered in line with current national standards and legislation. However there were concerns around the safe storage of medicines which was not consistently in line with trust policy and national guidelines. Patient records were not always stored securely. Access to services was inconsistent with significant delays in some specialties with a large number of patients waiting too long for their appointments. Staff demonstrated a commitment to patient-centred care. Patients were treated with dignity and respect and spoke highly of the staff. The staff were friendly, helpful and approachable. There were good links with other community services.



The Queen Elizabeth Hospital Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care); Surgery; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients.

Detailed findings

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Background to The Queen Elizabeth Hospital

The Queen Elizabeth Hospital is an established 488 bed general hospital which serves a population of approximately 240,000 people, from West and North Norfolk as well as Breckland, Cambridgeshire and South Lincolnshire. The trust provides a comprehensive range of specialist, acute, obstetrics, palliative care for cancer patients and other chronic illnesses and community-based services.

The Care Quality Commission (CQC) carried out a scheduled focused inspection at The Queen Elizabeth Hospital Kings Lynn between the 9 and 11 June 2015. The

trust had been placed into special measures in October 2013 due to serious failings and had undergone a full comprehensive inspection in July 2014 where we rated the trust as requires improvement. The trust was not compliant with regulation 11, safeguarding and regulation 13 for medicine management. We carried out the focused inspection in 2015 to review services that had been previously rated as requires improvement or inadequate and to consider the current status of the trust in relation to special measures.

Our inspection team

Our inspection team was led by:

Chair: Richard Quirk, Medical Director, Sussex Community NHS Trust

Head of Hospital Inspections: Fiona Allinson. Head of Hospital inspections, Care Quality Commission

The team included 11 CQC inspectors who had a range of professional background in healthcare including nursing, midwifery, paramedics and governance, one CQC pharmacy inspector and a variety of specialists including, two senior nurses, two medical consultants, a consultant in obstetrics and foetal medicine, a consultant surgeon, a consultant anaesthetist, a senior nurse in A&E services.

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?

Detailed findings

• Is it well-led?

The inspection took place between 9 and 11 June 2015.

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); Trust Development Authority; 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 carried out an announced inspection visit on 9 and 11 June 2015. 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.

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.

Facts and data about The Queen Elizabeth Hospital

The latest intelligent monitoring report published in May 2015 identified four risks and five elevated risks for the trust. The majority of these were related to the Well-Led section and the time periods for the indicators referred to when the trust was under its previous management.

Safe

Never event incidence – Elevated Risk

Incidence of Clostridium difficile (C.difficile) – **Elevated Risk**

Effective

Composite indicator: In-Hospital mortality – Haematological conditions – **Risk**

Our ratings for this hospital

Our ratings for this hospital are:

Well Led

Monitor - Governance risk rating – Elevated Risk

Monitor - Continuity of service rating – Elevated Risk

NHS Staff Survey - KF21. The proportion of staff reporting good communication between senior management and staff - **Risk**

Composite risk rating of ESR items relating to staff sickness rates - **Risk**

Snapshot of whistleblowing alerts - Elevated Risk

GMC - Enhanced monitoring - Risk

Detailed findings



Notes

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

Information about the service

The adult emergency department at the Queen Elizabeth Hospital in Kings Lynn last year saw over 57,000 patients. The paediatric emergency department was responsible for seeing and treating approximately 6,000 children during a year. The A&E department was originally built for 40,000 attendances but is currently seeing in excess of 60,000 attenders. The trust anticipates that this figure will rise by 3% per annum.

The trust have recently added an additional area for majors and observations as well as built a new paediatric emergency department. The outside of the building remains the same and children must enter through the main entrance for the emergency department.

During our inspection, we spoke to 22 members of staff including doctors, nurses and support staff. We also spoke with the management team consisting of the nurse consultant, matron, lead consultant and clinical director for the service. We spoke with eight patients including two children and three relatives as well as five visiting members of the ambulance service.

Summary of findings

Significant improvements have been made to the urgent and emergency services provided at the Queen Elizabeth Hospital in Kings Lynn since our last inspection in 2014. Services were effective, caring responsive and well led however still required some improvement in safety. Whilst the safety of the service had improved since our last inspection further improvements were still required. The service was not able to evidence all the care that was provided to patients because the records system, which was a combination of electronic and paper records, was difficult to navigate and disorganised and meant that completion of records was not good. The resuscitation trolleys had not been checked daily in line with trust policy, IV fluids were not securely stored throughout the department and the hand hygiene of medical staff in the department was noted to be poor.

Care bundles were in place and the care provided was in line with national guidelines and policies and staff were being developed to become specialised in emergency care within the service

Whilst the service was not always delivering against the four hour target or ambulance handover times they were one of the top performers in four hour performance in the East of England and recovered well from times of peak capacity and demand. The new emergency department for children was very responsive and was built in a way that met the needs of all children including those with complex needs.

The board and senior management were engaged in the service and incorporated the emergency department

(ED) as part of the trust so the department now felt integrated rather than isolated from other services. The culture of the service had changed significantly since our last inspection with the culture being open and transparent with good working relationships with most services now apparent.

Are urgent and emergency services safe?

Requires improvement

The safety of the service had improved since our last inspection however the service was not able to evidence all the care that was provided to patients because the records system, which was a combination of electronic and paper records ,was difficult to navigate and disorganised which meant that completion of records was not good. The poor records completion also impacted on the outcome of results in national audits where the poor completion of records meant that evidence of care could not always be presented. The resuscitation trolleys had not been checked daily in line with trust policy, IV fluids were not securely stored throughout the department and the hand hygiene of medical staff in the department was noted to be poor.

There was a good awareness and understanding of incidents with an open incident reporting culture. There was evidence of learning from incidents and mortality and morbidity meetings. Safeguarding arrangements were in place and were observed to be good although more challenge and improvement to this area to learn from events could be given. Nursing and medical staffing was sufficient with the exception of children's nurse staffing which required improvement to meet the guidelines.

Incidents

- The service had reported no never events since our last inspection. The service followed the trusts incident reporting policy and has reported 334 incidents in the previous 12 months.
- The incidents reported, in the majority, resulted in no or low harm for impact with the top reported incidents being low staffing levels, aggressive behaviour from patients who lack mental capacity or were under the influence of drugs or alcohol. The most reported incident was for patients who were identified as having a community acquired or pre-existing pressure ulcer whilst in the department.
- Three serious incidents were reported for the service between March 2014 and February 2015 which were linked to sub-optimal care of a deteriorating patient and delayed diagnosis.

- There was learning from incidents with detail shared amongst staff through meetings, handovers and through online forums, which we saw documented. We specifically asked five staff members if they could provide learning from an incident and all could recount an incident where they were provided with feedback and learning.
- Where serious incidents had occurred we reviewed the reports which had recorded that the families and the patients, where appropriate, where informed about the incident and the investigation in accordance with duty of candour requirements.
- The senior staff within the service informed us that they would routinely feedback to families if an incident had occurred even if the threshold for duty of candour had not been met. They informed us that they wanted to create an open culture around incidents and that there was "nothing to hide".
- The clinical director and lead consultant described what mechanisms the service had for reviewing and holding mortality and morbidity reviews. Reviews are done at 48 hours and then at the monthly meetings to identify any patterns trends or learning which would then be shared with staff. Though they also reported challenges in getting staff together for these meetings during busy periods.
- We examined the meeting minutes for March and May 2015 which supported that these meetings were held, patient cases were discussed and there were identified points of learning around record keeping which were to be shared with staff.

Cleanliness, infection control and hygiene

- At our last inspection there were concerns around the cleanliness of the department identified. During this inspection we observed that the department was clean and that more house keepers were available to support the improved cleanliness in the department.
- Patients who attended the department and were at risk of infection were isolated and their rooms were thoroughly deep cleaned prior to the next patient being able to use it. For example we observed a room where a patient was admitted with a sickness bug and after they were sent to a side room on a ward the bay was deep cleaned by domestic services prior to being used again.
- Equipment was visibly clean upon inspection and had been tagged with 'I am clean' labels.

- We observed amongst the nursing staff, healthcare support staff and housekeepers that good hand hygiene practices were adopted with staff using the hand gels and washing their hands.
- We observed poor infection control practice amongst the medical staff working in the department. We saw four doctors go between patients throughout their shift without washing their hands and type notes on the computer without washing their hands.
- We also observed two members of medical staffing not adhering to the uniform policy by wearing jewellery with jewels in and also more than one ring on at any one time.
- Infection control audits from February 2015 identified a 96% compliance with infection control practices and this had also highlighted hand washing therefore further improvements in this area are required and this was fed back to the clinical leads for the service.
- 73% of staff working in the emergency department had received mandatory training in infection control.

Environment and equipment

- At the last inspection in 2014 the environment was a concern as it was not suitable to provide care for the number of patients being seen, the children were also not seen in a separate area but seen in the main adult area.
- Some improvements were noted with the environment with the addition of new storage areas, a new majors area to provide capacity for seriously injured patients and also an additional observation area. This meant that the flow of the environment was improved however the staff acknowledged that due to the disjointed shape of the department communication amongst staff remained a challenge.
- The service opened a dedicated paediatric emergency department in April 2015 and this had been well received by patients, families and staff providing children's emergency care. The service did not have a dedicated entrance to the children's department and children still went through the main reception into children's area.
- The clinical leads for the service had aspirations to further upgrade and improve the environment in the centre of the department and wanted to redesign it to improve patient flow and improve the entrance to the emergency area of the hospital. This plan was being developed and had not yet been approved.

- We found two items of equipment, a fluid warmer and a sonography machine, which were out of service date and were still in use on patients. We informed the person in charge about these items and they notified the estates team.
- Resuscitation equipment on trolleys in the observation area and in the resuscitation area had not been checked daily as required by trust policy. In the observation bay the trolleys had not been checked for three days in February, four days in March, five days in April and two days in May 2015. Our audit of the stock in the trolley showed that it was fully stocked with all items required in an emergency.
- Within the resuscitation area there was a box of sharps stored on the floor under a computer desk. This contained used sharps and bags with blood and other bodily fluids in. These items should not be stored on the floor.

Medicines

- Medicines were stored throughout the emergency department. With the exception of the resuscitation area on the first day of our inspection the medicines cupboards were all locked and medicines were secure.
- IV fluids were not safely drawn up at all times, on the first day of our inspection we went into the medicines store room and a litre bag of saline had been drawn up but was left unattended, was not labelled and it was unknown which patient the fluids were for. The senior nurse in charge disposed of this item and spoke with staff about the risks of leaving IV fluids unattended, which is recorded on the departments risk register.
- IV fluids throughout the resuscitation area were open and exposed and could have been accessed by the public which was an ongoing concern for the service. The service leads informed us that they had received approval to change the cupboards in the resuscitation area so that the IV medicines are secured.
- A patient prescription and medicines administration chart audit undertaken in February 2015 showed that 94% of records were appropriately completed for medicines with two gaps identified around administration of VTE medicines.
- We noted a discrepancy in the recording of controlled drugs when we examined the controlled drugs book and cupboards. The matron for the service investigated this concern immediately and identified that the medicines were accounted for, they had however been moved as

an entry from one book to another by the pharmacy team without communicating with the nursing staff and it therefore looked like controlled drugs were missing. They informed us that they would raise this as an incident and speak with the pharmacy team to implement improvements.

Records

- The last audit on records carried out in November 2014 showed a compliance rate for completing records was 88%.
- 88% of staff had received mandatory training in health records management.
- We examined the records of 14 patients during our inspection and identified with the staff that there were challenges on completing the records between paper and electronic systems. In four cases the records were not completed fully.
- One patient who was discharged from the hospital was recorded on one system as being admitted to the Ambulatory Emergency Care Unit and in another record as being discharged. The records of their care around medical assessment were also not fully completed. The staff involved in the care acknowledged the records had not been fully completed but on observation it was understandable to the inspection team that this was due to multiple ways of recording and storing information. This example showed that records management requires review.
- Risk assessments for the patients who require them were undertaken in the department, though in the majority of cases assessments were completed in the ward areas. Any patient in the service for more than four hours was assessed using the inpatient assessment booklet.
- Of the national audits and local audits we reviewed relating to care including sepsis, feverish child and renal colic a key area of required improvement of records was noted through each as a consistent theme.
- We observed the care provided to patients with sepsis, fevers, urinary tract infections etc. during our inspection and found the care to be, in the main, in line with the national guidelines however the records did not support this. For example two of the records we examined were for patients with head injuries and in both cases neurological observations were undertaken however in

both cases the records of those observations were not recorded. Whilst we were assured that the appropriate care was being provided the records did not support this with evidence.

Safeguarding

- Training records for the department showed that 76% of staff had received safeguarding children training and 100% had received safeguarding adults training.
- There was a lead nurse for safeguarding adults and children in the hospital, their contact name number and pictures were displayed throughout the hospital.
- Of the staff we spoke with in the adult and children's department all knew who the lead nurse was and had regular dialogue with them.
- We observed staff complete a safeguarding alert for children during our inspection. They spoke with their named nurse, completed the form and ensured that all staff followed the safeguarding policy whilst providing care to the vulnerable patient.
- We also observed staff contact the safeguarding adults team about two patients in the department during our inspection, staff recognised the need to alert safeguarding and involved the named nurse promptly.
- Staff alertness to safeguarding was much improved however learning from events such as repeated drug overdoses could be improved. We observed that a patient who had been admitted three times in the previous 12 months with overdoses had not had their case reviewed to determine whether all appropriate care was given. We spoke with senior staff who acknowledged that they could do more around learning from cases where people are at risk of self-harm.
- We observed staff follow appropriate guidelines in using language line when concerned about safeguarding however they did not provide challenge to the team from another trust who conducted a psychiatric evaluation on a patient without an interpreter present. More work is needed to encourage staff to raise challenge when they recognise the practice is not appropriate.

Mandatory training

• Mandatory training was available to all staff who worked in the service. The emergency department staff compliance was 78% for fire training, 85% had been trained in resuscitation, 99% had received health and safety training, 87% received moving and handling training, 91% had received conflict resolution and 88% had received information governance training.

• The senior nursing and medical staff working within the department informed us that they had a clear programme to increase the compliance and attendance at training but had seen numbers drop during the winter due to high demand for the service which meant that staff were not always released.

Assessing and responding to patient risk

- The department has a defined streaming system in place for the patients who arrive into the department, and once streamed into the appropriate pathway then they will be triaged and then treated.
- Within the service there is a Rapid Assessment Team (RAT) who triage all priority cases and cases of concern. Along with medical staff the RAT team are also alerted as part of escalation of any concerning patients.
- The department used the early warning score system and staff had received training through mandatory training in understanding early warning scores.
- Associated with the early warning score there was an escalation protocol through the pathways linked with sepsis etc. for doctor and consultant intervention. This was clearly described in a flow chart for staff to read and was displayed throughout the department.
- The clinical lead, lead consultant and nurse consultant identified a risk around deteriorating patients being associated with the education of staff and the junior skill mix of some nursing shifts. They explained they needed to further develop staff understanding to recognise deterioration earlier and with a junior staff skill mix this could be a challenge. The senior team had a clear education and development plan in place to educate staff around deterioration and particularly sepsis.
- The nurse consultant identified that they were unable to observe the waiting room and that they did not have the nursing establishment to routinely monitor or staff the waiting room to identify any patient at risk of deterioration.
- As an interim measure they placed CCTV cameras in the waiting area which are observed by a staff member who often has clinical oversight to ensure that patients have

a better level of observation. The nurse consultant informed us it was their plan to increase staffing further through the next round of recruitment to allow better observation of unwell patients in the waiting room.

Nursing staffing

- The nursing vacancy rate had significantly decreased since our last inspection with four nurse vacancies noted on this inspection, all of which were filled and those staff due to start in July 2015. The service hoped that with the exception of sickness or maternity leave that they would be able to cease using agency to fill substantive shifts from July 2015.
- The nursing establishment on each shift had been increased by three whole time equivalent (WTE) since our last inspection.
- There had also been an increase in nursing leadership within the department with the appointment of three additional nurses to Band 7 roles giving the service four in total.
- The staffing levels for the service were assessed twice per day or more often depending on the demand for the service and additional staff were added to the shift if the acuity of patients increased.
- The skill mix for the service was a concern with many junior staff, as much as 35% being newly employed by the trust. Some were experienced nurses however the leaders of the service had recognised the skill mix of the service to be a concern and an area they had a clear plan to improve on.
- Of those agency staff employed by the service, the majority were familiar with the service and were regularly used by the trust. The senior nurses in charge informed us that it is their expectation that they are inducted locally at the beginning of each shift however they had found this was not always the case. This was an area they aim to improve upon should the need arise to use agency more frequently again.
- Within the children's emergency department, which was newly opened in a separate area of the building in April 2015, there was not a sufficient number of staff employed to meet the Royal College of Paediatrics and Child Health guidelines for staffing children's emergency departments with registered children's nurses. There were three children's nurses currently employed which meant that there were not enough registered children's nurses to work on each shift in the emergency department and some shifts were left without children's

nurse cover. In the week prior our inspection there had been seven shifts without registered children's nurse cover according to the staff rota. However the trust were mitigating this risk by seconding members of the children's ward to this are to ensure that all children were seen by a specialist nurse.

• Nursing handovers were done between staff in each of the zones within the department and between the nurses in charge of each shift. There was no whole team handover taking place and it was done variably through each layer of staff.

Medical staffing

- The department was staffed by 4 WTE permanent consultants and had one consultant on long term contract as a locum so there were 5 WTE consultants on the rota. The service is funded for 7 WTE consultants and the service has been continually advertising for these posts.
- The lead consultant had a clear understanding of the clinical standards of emergency medicine (CEM) requirements for medical staffing and that they needed to have 10 WTE consultants. There was a clear plan from the lead consultant to increase the consultant base with one due to be coming into the trust in the next three months and there were structures in place to recruit the trainees to consultant posts once they had passed their training exams.
- The consultants provided cover for 16 hours per day and then were on call out of hours.
- Handovers we observed that were conducted between medical staff were between the doctors only and the lead doctor spoke with the lead nurse for handovers. The handovers as mentioned above could be more dynamic and involve a wider team.
- The locums used in the department were used on a long terms contract basis and were familiar with the service. The rate

Major incident awareness and training

- The trust had a major incident policy and plan in place for major events.
- The service is linked with air ambulances and other military associated services to fly patients to the site in the event of an emergency and there is a helipad on site to safely deliver those patients.
- 95% of staff working in the emergency department had received major incident awareness training.

- The service had a link within the department who takes responsibility for the chemical, biological, radiological, and nuclear arrangements (CRBN).
- The service had arrangements, equipment and plans in place to deal with emergency events and decontamination of high risks diseases such as Ebola.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We did not rate the effectiveness at our previous inspection of urgent and emergency services in 2014 but on review at the inspection this year we found that the service was effective. The service had care bundles in place for the provision of high risk care including sepsis and there was evidence of clear pathways in place for conditions including chest pain and stroke. The CEM audit and outcomes had just been released and were not all available at the time of our inspection however local audits identified that improvements were required with records, which has been recorded in this inspection as a safety concern. As a result of poor records the audit outcomes were not all positive however the care observed showed that national guidelines and trust policies were being followed effectively. The service's performance on fractured neck of femur was affected due to the availability of the orthopaedic team although the ED did need to improve the fractured neck of femur pathway between the ED and the orthopaedic service.

Staff went through training, competency, development and revalidation processes at the trust and there were clear plans for further development of staff and the upskilling the skill mix of staff. Pain relief for patients was being offered and provided when required and we observed this in practice. Consent to care and treatment was taken and staff had a good understanding of the requirements and implementation of the mental capacity act and the Deprivation of Liberty Safeguards when needed.

We observed excellent multi-disciplinary team working internally between most teams and services during our

inspection particularly when urgent cases arrived in the department. There was also good multi-disciplinary team working noted between the service and external services such as the mental health and ambulance services.

Evidence-based care and treatment

- There was a clear protocol for staff to follow with regards to the management of stroke and sepsis. The department had introduced the 'Sepsis Six' interventions to treat patients. Sepsis Six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. Bundles were also available for neutropenic sepsis.
- We reviewed the policies and pathways for the admission of stroke, fractures and chest pain and these were written in line with the national institute for health and care excellence (NICE) and CEM guidelines.
- The fracture neck of femur pathway between the emergency department and the orthopaedic service required improvement. The department provided care to patients in accordance with CEM guidelines however they were unable to meet the key indicator of review by orthopaedic teams and transfer to the orthopaedic wards in a timely way due to the availability of the orthopaedic teams in attending the department to review patients.
- We spoke with two doctors and two nurses about the delays to fractured neck of femur patients and all said this was an area where they needed to improve. The same delays were not noted in the children's emergency department where it was noted by the staff in the children's area that the orthopaedic service were quick to respond to children's fractures when called for a referral.
- NICE and CEM guidance on sepsis, head injury and fracture neck of femur was not always being followed in the department because the care that was being provided was not being recorded. We have evidenced this further in the records section within safety. We observed the care provided and the care was good however the care provided was not always recorded which we determined was a records issue.
- The service undertook audits locally on a variety of topics including documentation, pain relief, medicines management, infection control and the environment.

The results of the audits showed that in relation to care evidence was not always available to support that the care was given because the records were not always well completed.

Pain relief

- The Maslow audit undertaken in March 2015 identified that of the ten records audited that 50% had a pain score completed.
- During the inspection we spoke with six adult patients and three relatives and of the six patients we spoke with three required pain relief, all had been offered pain relief and staff had returned to ask them specifically about pain levels however the pain relief and pain score box on the front sheet in two sets of notes had not been completed. Whilst the notes had not been completed we were assured during the inspection that the pain level of patients was being appropriately monitored.
- College of Emergency Medicine Pain in Children audit for 2014-15 was not yet available for this inspection. The audit from 2013-14 showed that improvement in the provision of pain relief for children was required.
- We examined the records of four children during this inspection, all four required pain relief for their condition and we noted that this was clearly recorded as offered on triage and a follow up on pain levels was undertaken at the time treatment with the doctor started which was an improvement.
- Of the two children and their families we spoke with, both had fractures, neither had any concerns regarding pain relief and were very happy with the service they had received.

Nutrition and hydration

- Food and drink was available to those who were in the department for any length of time, and when the department was busy a drinks trolley went through to ensure that patients had sufficient access to fluids.
- Food and drink was also available to relatives who were waiting in the department.
- The nutrition and hydration snap shot audit undertaken in February 2015 in the department showed that improvements were required from staff providing care in recording what had been given to patients to support their nutrition and hydration needs. This is another element which supports that (in safety) the management and completion of records requires improvement.

Patient outcomes

- The unplanned re-attendance rate within 7 days was at times lower than or similar to the standard and approximately 2.5% lower than the England average.
- The consultant sign off audit showed that about 16% of discharged patients and 8% of all admitted and discharged patients were seen by a consultant or associate specialist. 58% of discharged patients and 51% of all admitted and discharged patients were seen by an ED doctor of ST4 seniority or above. This was an area which required some improvement.
- The CEM audit on the fitting child showed that an eye witness account was fully taken in 79% of cases, 46% of patients with febrile convulsions received antipyretics and the service did not meet the key indicator with parents or carers being given information about seizures as no records were taken of any such discussion.
- The CEM Renal colic audit had just been issued at the time of our inspection however the result were unable to show progress since 2012 due to the service not completing the audit in 2012. The service had yet to analyse their outcome and therefore the results of this were not available.

Competent staff

- All medical staff within the emergency team had gone through the revalidation process with the GMC and where actions for improvement were identified through this process this was addressed through regular one to ones with the lead consultant.
- The appraisal rates for the department were 96% with 95% of nurses, 100% of support staff and 85% of doctors receiving an appraisal within the last 12 months.
- The nurse consultant and matron were aware that the nursing staff were going to be completing their nursing revalidation this year and were implementing support mechanisms for the staff to complete their revalidation process with the NMC (nursing and midwifery council).
- Competencies for staff were completed on items of equipment in the resuscitation area including defibrillators and echocardiograms (ECGs), we examined training and competency records for staff who used these items of equipment which supported what we were told.
- The nursing and medical leadership described training and development opportunities for staff within the service. There were opportunities to obtain further

education and qualifications for role specific qualifications such as physician assistants, advanced nurse practitioners, nurse prescribers which were being thought about and well received by staff.

- There were promotion opportunities for career progression in the service which were lacking at our last inspection and staff who had recently been promoted were supportive of this development and said it had encouraged them to want to stay at the trust.
- There had been development for medical staff that had joined the Trauma Intensive Life Support (TILS) Training scheme with the centre being designated as a training centre for this training to be delivered by medical staff. The three medical staff we spoke with were encouraged by the new opportunities available.

Multidisciplinary working

- There was a notable level of respect between the different professionals working in the department. Nursing and medical staff were observed to work well together and with open lines of communication.
- The team worked well with the surgeons and medics who attended the department for referrals with the exception of orthopaedics where there was some notable tension around the time taken to attend the department following referral for adult fractures. This was observed on three occasions during the inspection.
- We saw excellent multi-disciplinary team (MDT) working on more than one occasion when a patient was rushed into the department as an emergency. The team from the emergency department, intensive care, anaesthesia, medical, nursing and even to the house keeper worked in unity when these cases arrived and it was clear that the team working in the service worked well.
- We spoke with four members of the ambulance service who reported that there was a good working relationship with the staff in the department and that they were happy to attend the service and work with the staff.
- The trust had a mental health liaison team who were employed directly through the trust to support care to patients who attended with complex mental health needs. There was a good working relationship between the staff and the department.
- Psychiatric and mental health services were available from the mental health trust which covers the Norfolk area. We saw the team engage this service when a referral was made urgently to them for assessment and

support. We were informed by the staff that the service worked well though communication could be improved at times particularly around treatment and discharge/ transfer plans or arrangements.

• The team worked closely with the ambulatory emergency care unit and ensured that appropriate patients were referred over to the care of this service when needed.

Seven-day services

- The emergency department is open seven days per week and twenty four hours per day.
- There is a GP access service available on site as well operated jointly by the trust which was also open seven days per week but for 12 hours per day.
- Radiology services currently do not operate seven days per week but on call services were available for emergency cases when needed to support the service.

Access to information

- The records system used within the emergency department was disorganised because the service used a combination of paper records and electronic records. Access to all systems was not a concern as all information required to provide the care to patients was accessible at any time however it could be time consuming to locate when it was not all stored in the same place.
- The three nurses and three doctors we asked about the records system informed us that they were used to the system however access to information in the same area could be improved. The clinical leads for the service when asked also acknowledged that access and streamlining of information could be improved.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Of the front line staff who required consent training in the emergency department 95% had received it however only 55% of medical staff had received the training.
- Dementia awareness training had been completed by 95% of nursing and support staff and 61% of medical staff.
- Mental Capacity Act awareness training had been completed by 99% of nursing and support staff and 61% of medical staff.

- Learning Disability awareness training had been completed by 98% of nursing and support staff and 61% of medical staff.
- During the inspection we observed patients being asked for consent prior to entering their bay area, and asked for consent prior to staff taking observations or medical staff conducting examinations.
- Consent was taken prior to any diagnostic tests being undertaken and this was well recorded in the clinical notes section of the three records we examined where diagnostic tests, in this case x-rays and CT scans, had been requested.
- Where a patient exhibited signs of confusion on examination the medical staff completed an abbreviated metal awareness test to determine the level of confusion they may have. If the patient was over the age of 75 they also undertook a dementia screening. If there were concerns about a patient's mental capacity from these tests then the procedure was for a full mental capacity assessment to be completed.
- We observed the staff complete a mental capacity assessment on a patient where they had concerns, and they determined that the person did not have mental capacity and also consulted the safeguarding lead nurse to request for a deprivation of liberty safeguard until their mental health could be assessed by the mental health trust. This process we observed worked well for the patient.

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

The services provided to adult and children at the hospital were responsive and had improved significantly since our inspection in 2014. The service had access to a range of specialist nurses and support services to provide care that meets people's individual needs including those with dementia, learning disabilities and mental health needs.

Good

The children's emergency department was new and opened in April 2015, the service was very child orientated and had been designed to meet the complex needs and challenges of providing care to children and elements of the design including the sensory equipment installed in the waiting area and portable devices was excellent.

Whilst the service was not always delivering against the four hour target or ambulance handover times they were one of the top performers in four hour performance in the East of England and recovered well from times of peak capacity and demand. However performance was in line with the national average.

There was a range of leaflets available for people with conditions to read whilst in the department or on exit, whilst these were provided in English other languages were available through the staff upon recognition that the first language was not English. There was evidence that staff had learned from complaints and concerns and had implemented changes to improve the service.

Service planning and delivery to meet the needs of local people

- The service recognised that there was a need to support the regular needs of patients with higher risk clinical conditions and this function was supported by the ambulatory emergency care unit. This unit took patients who required additional acute medical support but not admission to hospital. This service was an outstanding use of resource which had a positive impact on the delivery of the emergency department function.
- The opening of the children's emergency department in April 2015 was a positive improvement on meeting the needs of the local people with the number of children's attendances increasing continuously each year.
- The service was working with the commissioners, the primary care service and ambulance service to establish lines of care to work on reducing the number of admissions and attendances to the department given the aging population. Consideration is being given to this through the service's vision and strategy for the service through to the year 2020.
- Children had ready access to paediatric services internally but were operationally continuing to work with children and young people's mental health services (CAMHS) to ensure that services for children and young people could be accessed in a more timely way.

Meeting people's individual needs

- Mental health liaison services were available in the trust Monday to Friday, and an out of hours service was available at the weekends. Access to mental health services were available through the local mental health trust who would respond to care when needed.
- We observed the working relationship with mental health liaison and the mental health trust during our inspection and staff had access to these quickly to deliver the care needed to a patient who was unwell.
- We observed the staff access the translation service, known as language line, when they were trying to communicate with a patient whose first language was not English. This telephone service was available to the department 24/7.
- The service had tried to get an interpreter to attend in person but said this was often a challenge with their location in Norfolk as people cannot always get there. The relative was able to translate for them on all basic communication except the questions they needed to ask about care for which they used language line. However the visiting team from another trust used the relative to translate when they conducted a psychiatric evaluation, which we raised with the nurse in charge who said it would be reported.
- There is a named nurse for learning disabilities and staff had received training in understanding learning disabilities and complex needs. The LD nurse was available Monday to Friday however information is available to staff on the intranet to support them with a patient who has complex needs if required.
- The trust has a named nurse for dementia and the service had access to this person Monday to Friday where needed for advice and guidance.
- There was information available in the department for people with Dementia and there were dementia friendly signs displayed and one of the male toilets and one female toilet were colour coded to be classed as dementia friendly.
- Leaflets on a variety of conditions including back pain and flu as well as choosing the right pathways of care and when to choose emergency care were available to patients in the reception area.
- The leaflets available were in English only although other languages were available where the first language was not English.

- The waiting area in the children's emergency department had been designed and built with children at the centre of the design. The area was very colourful and there were plentiful toys and DVDs for children to watch.
- The waiting area had a dedicated area in the ceiling and in the corner of the waiting room with sensory lighting and equipment for children with complex needs or learning disabilities. The service, we were told by a nurse, sees at least one child with complex needs per day and the sensory equipment had helped keep them calm whilst waiting.
- There was a portable sensory machine with lights, bubble machine and projector available in the treatment room within the children's area and this was moveable throughout the service.
- We were given an example during the inspection when it was moved to the resuscitation department to help a child remain calm after being admitted with a traumatic injury. The records for this child noted that they were clam and happy when receiving the treatment and staff linked that to the availability of the sensory equipment.
- Between the hours of 4pm and 8pm during the week the service had a play specialist (who was awaiting qualification). Their role was to provide support to children waiting in the waiting room during busy periods. The two children and their families we spoke with could not praise this person enough, all people we spoke with were highly positive about the impact this person had on the department when it was busy.
- The pathways for patients with fractured neck of femurs in the emergency department needed to improve.
 Patients were not taken to the ward in a timely way due to the procedure in the trust being that orthopaedic staff must review the person in the department prior to them being admitted to the ward. Due to delays in the orthopaedic staff attending the ward there were often delays in getting patients to be seen within two hours as per the national standards from CEM.
- There was no gynaecology pathway for the trust which meant that women who miscarry or suffer an ectopic pregnancy must go to the emergency department. Due to bed availability there is no priority to admit women through the service to the surgical wards as there were no 'ring fenced' or priority beds for gynaecology patients. We were provided with two examples from staff where patients had to wait in the emergency

department and have their miscarriage. The nursing staff informed us that they tried to be as responsive as they could to the women coming through the ED but at peak times this was challenging.

In one example they brought a young women into the department to have a miscarriage in the resuscitation area so they were not sat in the waiting room, this gave them the privacy they needed as there was no beds available in the hospital. The service felt this was not responsive to the needs of women.

Access and flow

- The layout of the department being in individual zones made the system challenging to observe the capacity and flow throughout the department. Each of the five zones were in individual areas and this meant that identifying peaks and demands on capacity was a challenge and were often not picked up until the service was at a really busy point.
- The flow of the service had been significantly improved by the management of bed capacity within the hospital. At the last inspection the department felt blamed for the flow issues with capacity in the hospital, this was no longer the case. The Clinical Director told us that it had been realised within the trust that "if you sort the bed flow and capacity then the ED runs itself." With capacity in the hospital available we observed that the flow within the ED worked well throughout the duration of the inspection.
- During the inspection there was one day where there
 was a lack of female beds within the hospital and many
 patients attending were female. We observed good use
 of the escalation protocol when this was identified by
 the team and the operational team came down to the
 department and left with information to find a solution.
 We observed that the flow improved during the day and
 the problem with female bed capacity was resolved in
 the majority.
- The percentage of patients leaving before being seen was consistently lower than the England average from February 2013 to September 2014.
- The percentage of patients waiting between 4-12 hours had been varied between March 2013 and January 2015 and whilst it had predominantly been similar to the England average, there have been notable rises in April and October 2013 and December 2014 which are not in line with national trends.

- The trust struggled to meet the 95% target for patients being seen within 4 hours. The trust was averaging 80-95% in the two months prior to our inspection which put them in the top five trusts for performance against the 4 hour target in the East of England.
- Time to triage has been consistently above the 15 minute time frame required for both walk in patients and those who attend through ambulances. However the time to treatment start is consistently below the 60 minutes time frame and the trust performed better than the England average on this target.
- The trust has performed worse than the England average over the previous three months with ambulance handovers being delayed more than 60 minutes, it was noted that this was a particularly busy period for demand on the hospital.

Learning from complaints and concerns

- Complaints and concerns are discussed at each team meeting with staff as well as at divisional governance meetings. We viewed minutes of meetings at all levels which supported that learning from complaints was discussed.
- The service had also set up a private Facebook group with restricted access for the emergency department staff only through which learning of outcomes and sharing themes and trends are shared to all staff for them to view remotely.
- We could see examples of where changes were to be made to support patient feedback, an example being access to drinks and the implementation of the drinks trolleys during the day and evening. We observed that these changes had been implemented during the inspection.
- Information on how to report a complaint and where the Patient Advice and Liaison Service (PALS) are located in the hospital was available for patients and staff were aware how to raise concerns if they had any.

Are urgent and emergency services well-led?

Urgent and emergency services were well led and there had been significant improvements in this area. There was a clear statement of vision and values, driven by

Good

quality and safety. The senior leadership team had a clear strategy which will take the service through to 2020 with clearly defined objectives that are regularly reviewed to ensure that they remain achievable and relevant. The vision, values and strategy were understood by staff who understood what challenges the service faced and what the vision was for the service going forward.

The board and senior management were engaged in the service and incorporated the service as part of the trust so the department now felt integrated rather than isolated from other services. Quality of services now received sufficient priority and support to improve the systems in place. The culture of the service had changed significantly since our last inspection with the culture being open and transparent with good working relationships with most services now apparent.

The leadership structure had changed with implementation of new leaders at different levels of the structure and more leadership posts being created and appointed to. The leadership team were solid and cohesive and worked well to deliver improvements throughout the service and their leadership style was recognised and respected throughout the workforce.

Vision and strategy for this service

- There was a clear vision and strategy for the emergency department which takes the service through to the year 2020 to deliver changes and drive improvement and sustainability.
- There was a trustwide vision and strategy which had been released and was displayed throughout the hospital.
- We spoke with staff at all levels about their understanding of the vision for the emergency department and all were able to demonstrate that they understood the vision for the service, the challenges ahead and the changes to be made. The feedback provided to us on the vision for the service was consistent from all grades of staff we spoke with.

Governance, risk management and quality measurement

• The division had monthly governance meetings to look at risk management, governance and quality issues

throughout the service. We examined meeting minutes for the last meeting which demonstrated that issues around governance in the emergency department were discussed.

- The emergency department had a risk register in place which did have several key risks on it and the top risks were also displayed on the trust corporate risk register.
- The top risk for the service was around access, flow and delivery with the department being too small to cope with the yearly increasing demand in capacity. Medicines management and medicines security was also recorded as a top risk on the risk register.

Leadership of service

- The leadership of the service had undergone a restructure since our last inspection. There are now additional nursing leaders in post at Band 7 level as well as matron level.
- The clinical director was a surgeon which provided a different perspective on the requirements of the emergency department but their impact on the service was positive as it had helped to engage the surgeons, medical staff and the ED together.
- The lead consultant was known as the leader in the service and all the medical staff we spoke with in the department spoke highly of their leadership skills and their commitment to driving change in the service.
- The leadership of the service was engaged with the operational and divisional leadership team who were visible in the department when support was required.
- The trustwide leadership team was engaged in the service and were visible when support was needed and were also a recognised area of support in changing the view of the emergency department within the trust. The staff we spoke with about leadership in the department said that the senior leaders now recognised the work of the department and were supportive in driving change and good quality care rather than penalising them for target breaches.

Culture within the service

• At our last inspection the service was isolated and we were told that staff felt as though the ED was an island and separate from the rest of the hospital. At this inspection the culture had seen significant changes and notable improvements had taken place with the team now feeling part of the hospital and engaged in what was happening elsewhere in the trust.

- The clinical director told us that the trust had now recognised that the failures and breaches are not the fault of the ED but rather a consequence of a pressured system and if the system works then the ED works too.
- All staff we spoke with in the department reported improvements in the way that the service now ran and that the attention was now on the service for the right reasons rather than the service being "blamed for the failures".
- All staff we spoke with told us that they were now happy in their work and proud to work for the hospital and that they now felt respected and valued as members of the team.
- The staff spoke to each other in an open, courteous and professional manner which was a significant improvement on our last inspection. Staff addressed each other by their professional title then name for example "matron", "sister", "nurse" or "doctor". It was positive to see the level of respect staff had for each other working as a team in the department.

Public engagement

- The service takes part in the Accident & Emergency inpatient survey and also takes part in the A&E friends and family test. There were comments cards and feedback forms available throughout the service to engage the public in providing feedback or ideas for improving the service.
- All patients were given comment cards upon leaving the service to provide feedback specifically about how the service could improve and seek feedback to implement changes where needed.

Staff engagement

- The change in culture from a closed culture in 2014 to a more open culture in 2015 was evident as we observed staff openly approach the management team to raise concerns about capacity, flow, patient safety or equipment where needed. All concerns were welcomed by the leadership team who responded to the questions that were raised.
- There is a whistleblowing policy within the trust, staff were aware of the policy. All staff we spoke with told us that they felt that they could raise concerns to the management team within the department and that those concerns would be listened to.
- The clinical leads for the service told us that it was important that staff raised concerns and that they provided a culture where staff were happy to do so.

Innovation, improvement and sustainability

- Despite financial constraints the trust had invested in the emergency department since our last inspection with some improvements to the environment and an increase in the nurse staffing establishment.
- The nursing and medical leaders informed us that they were planning to further look at the sustainability and development of the service going forward as part of the vision for the service.
- The team want to innovate themselves to become an outstanding emergency department that provides good care to their population and informed us that this was their aim and what they were working towards by demonstrating continued improvements through sustainability.

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

Information about the service

The Queen Elizabeth hospital has 283 beds across the medical inpatient wards and provides for patients requiring care for a number of conditions including stroke, gastroenterology, oncology, respiratory, care of the elderly and general medicine. The stroke unit provided hyper acute care and thrombolysis.

We spoke with 34 members of staff, 21 patients and their relatives. We visited 7 clinical areas, reviewed records and observed care during the inspection.

Summary of findings

Medical services required improvement in safe because records and risk assessments were not always completed patients reassessed and the medical records and nursing risk assessments were not always consistent. Some ward areas were cluttered and there were some infection control risks identified. Nurse staffing had improved but did not always meet national guidance in relation to specialist respiratory care. There remained on-going challenges in relation to medical staffing. We found that medical outliers were all identified and cared for.

Care and treatment was evidence based. We saw that patient pathways and care bundles were underpinned by national and local guidance. Pain relief was prescribed appropriately and given in a timely way. Nutrition and hydration was adequately managed and we saw patients had bottled water within reach during our inspection. Audit data for stroke showed the trust to be performing poorly but we were told this was a data collection issue. There was effective multidisciplinary team (MDT) working and seven day services including occupational and physiotherapy.

Services were planned to meet the needs of local people. Referral to treatment times met national targets and there had been innovative work to reduce length of stays. Admission to the stroke unit (within four hours) was failing to meet the 90% benchmark. There was effective discharge planning and services were

responsive to people's needs including named consultants and availability of specialist equipment. Complaints were properly investigated and learning disseminated to staff.

The medicine directorate was well led as there was a clear vision for the service as well as detailed strategic plans for the development of services; however we found that not all staff were fully aware of them. There was a robust ward to board governance structure and we saw that senior managers had a clear idea of the risks within the directorate. Staff spoke highly of the leadership of the service and senior directorate managers felt well supported by the new substantive board members. All staff we asked told us there had been a positive shift in culture under the new leadership, staff felt supported and able to raise concerns.

Are medical care services safe?

Requires improvement

Medical services required improvement in safe because records and risk assessments were not always completed, patients reassessed and the medical records and nursing risk assessments were not always consistent. Some ward areas were cluttered and there were some infection control risks identified. Nurse staffing had improved but did not always meet national guidance in relation to specialist respiratory care. There remained on-going challenges in relation to medical staffing.

We found that medical outliers were all identified and cared for. Incidents were reported and lessons learnt. Medicines were stored correctly and most staff were up to date with mandatory training. Staff demonstrated a good knowledge of safeguarding and there were clear safeguarding processes in place.

Incidents

- Incidents were reported, investigated and lessons learnt. Incidents were reported using an electronic system.
- There had been 58 serious incidents reported prior to our inspection, with the vast majority (42) being grade 3 pressure ulcers. Data showed that falls and pressure ulcers were generally on a downward trend over the last year.
- Incidents were audited and monitored at ward level feeding into the overall governance structure.
- We looked at the serious investigation reports from incidents and saw that there had been full investigations. Learning from the incidents had been recorded along with agreed actions.
- Staff we spoke with told us that they were confident in reporting incidents and that they received feedback about incidents they reported, normally at meetings. Learning from incidents was disseminated to some staff through a monthly newsletter. Staff told us that they read the newsletter and we saw that staff had signed it to say they had read and understood it.
- Eight staff we spoke with were aware of duty of candour and the requirement to be open and honest.

• An annual incidents and trends report was completed in May 2015 with identified themes in incident reports and developed actions in relation to themes identified.

Cleanliness and infection control

- Ward areas appeared visibly clean. We saw that compliance with cleanliness audits was at or above 95% for all medical wards.
- On one ward the floor had been repaired in a number of places by tape. We were concerned that this was not easily cleaned and so posed an infection control risk.
- On another ward boxes containing deep suction catheters were torn open and left at the bedside or, on one occasion, on a patients table. We were concerned that this posed an infection control risk.
- Bed curtains were clean and changed regularly.
- Staff were aware of infection control principles, policies and procedures. Staff were bare below the elbows in clinical areas in line with trust policy. However, on one occasion on the medical assessment unit (MAU) we saw a nurse leave a room with gloves on and touch a number of pieces of equipment before removing them.
- There were hand washing facilities and personal protective equipment for staff. We observed these being used appropriately. Compliance audits for hand hygiene were at 100% in most areas we inspected.
- Side rooms were available for patients who required barrier nursing and isolation with clear signage that staff and visitors should wear personal protective equipment (PPE) prior to entry to the room.
- An infection control action plan had been created and implemented since our inspection in 2014 and addressed the concerns identified. The action plan indicated that almost all of the key issues had been addressed.

Environment and Equipment

- Most clinical areas were well organised but we found one ward cluttered with medical and other equipment. Oxborough ward had numerous pieces of clinical equipment including non-invasive ventilation (NIV) machines, blood pressure machines and wheelchairs, a pressure relieving mattress and drug trolleys in bays and in corridors.
- Equipment was properly maintained in line with manufactures recommendations.
- Staff told us that they did not have difficulty in getting necessary equipment when it was required.

• Emergency equipment was available in each area and records showed it was checked appropriately. Two staff we spoke with told us that they regularly checked the emergency equipment.

Medicines

- We reviewed the prescription and medicine administration records for 12 patients on three wards. Appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed .The records showed patients were getting their medicines when they needed them, any reasons for not giving their medicines were recorded. This meant patients were receiving their medicines as prescribed. If patients were allergic to any medicines this was recorded on their prescription chart.
- Medicines, including those requiring cool storage, and controlled drugs were stored appropriately. Controlled drugs are medicines which are stored in a secure cupboard and their use recorded in a separate register.
- There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. This meant that patients had access to medicines when they needed them.
- The pharmacy team visited all wards each weekday. Pharmacy staff checked that the medicines patients were taking when they were admitted were correct, that records were up to date and the medicines were prescribed safely and effectively.

Records

- We looked at 18 records and spoke with staff about patients care. Records were paper based and the medical notes were multidisciplinary with doctors, nurses and allied health professionals writing in the same notes.
- Risk assessments were completed for pressure area care, mobility, moving and handling and nutrition amongst others. We reviewed 23 records and found that 15 had not had risk assessments updated to reflect changes in patient condition.
- Five records did not have a falls risk assessment or management plan completed.
- A further five care plans did not have updated Waterlow (pressure ulcer) risk assessments updated to reflect changes in patient condition.

- Four other nursing assessment records were not consistent with medical notes, for example medical notes identified a patient with cognitive impairment which was not reflected in the nursing record.
- There were printed care bundles for conditions such as sepsis and infective exacerbation of COPD (chronic obstructive pulmonary disease) amongst others. These were adhesive and should be stuck into patients notes with the counterfoil being submitted for audit. Whilst staff clearly followed guidelines, they did not always complete the care bundle in the records. We saw four records were patients were being cared for in line with the bundles but these were not available in their records.

Safeguarding

- There was a policy and procedure in place for identifying and reporting any safeguarding issues.
- In a number of clinical areas information regarding safeguarding was clearly visible for staff with instructions on how to make a safeguarding referral. One patient who had been identified as a safeguarding concern (for an incident occurring outside of the hospital) had been appropriately referred and the concerns recorded in their medical records.
- We spoke with eight members of staff regarding safeguarding. Seven of the staff had a good knowledge of safeguarding principles and were clear about how to make a referral to the safeguarding authority.

Mandatory Training

- Staff undertook a range of mandatory training including immediate life support and moving and handling amongst others.
- On the medical assessment unit (MAU) the practice development nurse had developed a comprehensive system for ensuring all staff had received appropriate mandatory training and as such, compliance rates were high on this ward.
- Compliance rates were variable but most wards were up to date with mandatory training. The training matrix we saw in four ward areas confirmed this. However data provided by the trust shows that the medical services group did not achieve its end of year targets in mandatory training in fire (82%), infection control (71%) and resuscitation (68%). The practice development nurse were actively seeking to address this.

• 12 staff we spoke with confirmed that they had received mandatory training as both ELearning and face to face teaching.

Assessing and responding to patient risk

- The medical wards used an early warning score (EWS) to identify patients at risk of clinical deterioration and ensure escalation to receive appropriate care.
- The trust had considered implementation of NEWS (national early warning score) but had provided a clear, evidence based rationale as to why this early warning score would not be implemented at this time.
- The intensive care outreach team supported staff and patients who were identified as at risk of deterioration.
- There were clear processes in place for the transfer of unwell patients to either a critical care bed in the hospital or to transfer patients to another service. Cardiology staff we spoke with told us about the arrangements they had to transfer to a regional cardiothoracic centre for patients requiring specialist intervention.
- 14 records we reviewed showed that the EWS was completed at each set of observations and that they were totalled correctly. In two records, where a patient was identified as having a high EWS score, this was escalated appropriately to the medical team and / or outreach team for review.
- On our last inspection in 2014 we found that medical and nursing staff were not always sure or did not know about medical patients being cared for on other wards other than their own. We found there to be a serious risk of patients not receiving appropriate care and treatment. On this inspection we found that action had been taken and that patients were now clearly identified when they were cared for on other wards. There was a named consultant identified for each patient.
- Junior doctors had also created a database for patients being cared for on other wards so that at handover, they could be properly identified, discussed and tracked during their stay in the hospital. Staff we spoke with told us that they had no concerns with getting outlying patients reviewed.
- Guidelines for identifying medical outliers had been agreed in May 2015 which included named consultants for medical outliers placed on surgical wards.
- Two consultants now shared the out of hours responsibility. It was believed this had positively

impacted and reduced the number of outliers. An audit paper competed between January 2015 to April 2015 showed a steady reduction in the number of medical outliers.

Nursing staffing

- The number of nursing staff working on each shift was clearly visible at the entrance to the ward. In most instances the actual number of staff working was the same as the planned number.
- There were variable vacancy rates across medical wards but there had been significant recruitment in most areas. There had also been a recent uplift in nursing staff based on the safer nursing tool audit completed prior to our inspection. A review of nursing staffing had been completed 6 monthly for the preceding 18 months.
- Where there were vacancies, agency and bank staff were used to ensure the correct number of staff were available. These staff were appropriately inducted to the wards on which they were working.
- There were however gaps in nursing cover on some wards. On the stroke unit which has a high acuity patient mix, we saw that between 1st and 28th May, there were 19 occasions when a shift was short of one nurse and one occasion when they had been short of two nurses.
- We were told of some concerns of skill mix given the recruitment of new nurses and a number from overseas. Directorate management were aware of these concerns and identified skill mix as an area to be developed. On the MAU this was mitigated by a comprehensive tailored induction.
- On Oxborough (respiratory) ward we saw that they cared for patients requiring non-invasive ventilation (NIV). There were five machines on the ward but we were told it was rare to have that number of patients being cared for with NIV. At the time of our inspection we found that one patient was being cared for with NIV on the ward and two patients with a tracheostomy and 30 other respiratory patients. Working on the shift were five nurses (instead of six) and four health care assistants. British Thoracic Society 2008 Guidelines state that there should be a minimum staffing ratio of one nurse to two patients for at least the first 24 hours of NIV, though we were aware the majority of NIV patients were commenced in MAU or ITU. We were concerned that the

acuity of some patients was not reflected in staff numbers nor was there a robust system to consider staff numbers in relation to NIV with potentially 6 NIV machines available.

- We reviewed the outline business plan for the new proposed acute bay on Oxborough. We were concerned that the proposed staffing levels, particularly at night would not meet the national guidance from the British Thoracic Society.
- Senior staff told us that they reduced the number of beds on Oxborough ward in relation to the acuity of the patients.
- There had been an uplift in staffing across the medical directorate. However, staff told us that there had not been any flexing in relation to patient acuity. One ward manager told us they did flex staff in relation to acuity of patients but could not show us a tool or audit used. Senior managers had told us that an acuity tool was used twice a day.

Medical staffing

- The trust had the same number of consultants as the England average, but less registrars (specialty trainee's) than the England average whilst having more junior doctors than the England average.
- Both cardiology and respiratory specialities provide consultant led ward rounds Monday to Friday and an on call service overnight. The trainees confirmed that they had no difficulty getting consultant advice when a consultant was off the wards.
- All medical specialities had consultant led board rounds Monday to Friday.
- All the consultants spoken to said that they would manage other consultant's patients when the patient's named consultant was off site. This was confirmed by specialist nurses and junior staff.
- At weekends and on bank holidays there was no consultant respiratory or cardiology rota. The cardiologists confirmed that they would respond if possible to a telephone request to perform pacing or echoes and provide specialised advice. If they were not available verbal advice was obtained or transfer arranged to Papworth. This system was described as 'ad hoc' and relied on goodwill and the ability for staff to be able to make contact.

- If a respiratory physician was on site as part of the on call medical rota they would review sick respiratory patients in the hospital, otherwise this was done by the on call physician or medical registrar who would review NIV patients.
- A fourth respiratory consultant had been appointed who, it was envisaged, would help support weekend cover for respiratory patients.
- Both specialities said that they would wish to provide a seven day specialist rota but that would require considerable changes to working practices and contracts as there was also a need to manage outlying clinics or working at other acute trusts.
- Senior staff recognised that medical staffing was under pressure but had recently made a number of appointments including a new cardiologist and gastroenterologist.
- Whilst there was ongoing locum use, we saw that the locums were on long term placement.

Major incident awareness and training

- The trust had a major incident and escalation policy. Staff we spoke with were aware of the policy and where to locate it.
- The policy included contingency plans in the event of an external or internal incident and the transfer of acutely unwell patients to other hospitals.



Care and treatment was evidence based. We saw that patient pathways and care bundles were underpinned by national and local guidance. Pain relief was prescribed appropriately and given in a timely way. Nutrition and hydration was adequately managed and patients had bottled water within reach during our inspection.

Audit data for the stroke service showed the trust to be performing poorly but we were told this was a data collection issue. Other audit data for the hospital showed it to be performing broadly in line with the England average. Staff were given the opportunity of additional training but we did not receive assurance that competency assessments for some skills were always completed. There was effective MDT working and seven day services including occupational and physiotherapy. Staff were aware of the mental capacity act and we saw appropriate use of the deprivation of liberties safeguards (DoLS).

Evidence based care and treatment

- The medical service provided care and treatment in line with guidelines from the National Institute for Health and Care Excellence (NICE). Local policies were written in line with these guidelines.
- During our last inspection in 2014 the stroke pathway was not in line with NICE guidance. On this inspection we found that the pathway had been updated and was in line with national guidance.
- Patient pathways in cardiac, respiratory and diabetes followed NICE guidance and had been regularly reviewed.
- There were care bundles in place for a number of conditions. These reflected best practice and national and local guidelines. We saw from records that care was provided in line with these bundles.
- Staff we spoke with were aware of key national guidance in the areas they were working.

Pain relief

- We saw that pain relief was prescribed and administered in a timely way. Pain was assessed using a scale.
- There was a pain control team and for palliative care patients, a Macmillan team provided specialist advice on pain relief.
- Patients pain was identified as part of an assessment and that the assessment was acted upon.
- Pain relief was available in a number of ways for example, orally, by injection or by subcutaneous continuous infusion for patients who were unable to take oral pain relief.
- Seven patients told us that their pain had been controlled and that they had been given pain relief when they had requested it.

Nutrition and hydration

• Patients had their nutritional status assessed on admission and were referred to a dietician or specialist if any concerns were noted. We saw three records where patients had been identified as at risk and they were referred appropriately to other professionals.

- Patients that required additional fluid were prescribed intravenous or subcutaneous fluids. Those we reviewed were running to time.
- There were additional forms of nutrition available such as percutaneous endoscopic gastrostomy (PEG).
- Patients on the stroke ward were assessed for their swallowing reflex in a timely way to ensure they received the appropriate diet and nutrition.
- There were protected meal times for patients. Those patients that required assistance were helped in an unhurried way.
- The trust was providing bottled water to patients. We were told that this had improved patient hydration but that this had not been measured. We observed drinks to be within reach of patients and assistance with drinking offered as required.

Patient Outcomes

- The readmission rate for elective general medicine was better than the England average, at 80 with performance worse than the England average for elective haematology and oncology patients at 130 and 123 respectively. For non-elective patients, the trust performed better than the England average for medical readmissions with all rates below 100.
- Most recently available data from Sentinel Stroke National Audit Programme (SSNAP) for July to September 2014 showed that the trust scored in the highest band A for case ascertainment rate however scored in band D overall. Audit data showed there was good access to thrombolysis but response to therapies was poor. Therapy staff we spoke with told us that they now provided therapy to stroke patients within 24 hours.
- In contrast to SSNAP data, hospital data showed that for February 2015 that all patients were scanned within 60 minutes and all patients with confirmed stroke were scanned within 24 hours.
- We were told that the poor performance on SSNAP was because the initial dataset was not captured promptly. To remedy this, a business case had been approved to recruit data clerks to ensure prompt reporting in the future.
- On the stroke unit there was a thrombolysis practitioner on shift at all times meeting the national guidance and standards.

- The national heart failure audit showed that the trust performed better than the England and Wales average for input from a specialist and patients receiving an echocardiogram but worse than the average for input from a consultant cardiologist.
- The hospital performed better than the average for referral to cardiology follow up and patients being prescribed appropriate medications but worse than the average for referral to a liaison service. The hospital performed better than average for four of the seven indicators.
- MINAP audit data showed that the trust performed better than the England average for nSTEMI (non ST-segment elevation myocardial infarction) patients referred for or had angiography but worse than the England average for nSTEMI patients seen by a cardiologist or admitted to a cardiac ward. Hospital performance between 2012/13 and 2013/14 was broadly similar.
- The National Diabetes Inpatient Audit for 2013 showed that the hospital performed better than the England median on 15 indicators including seen by MDT in 24 hours and suitable meals being available. It scored worse than the England median on six indicators including staff awareness of diabetes and meal timing.
- Audit data for April 2015 showed that for patients with a high risk transient ischaemic attack (TIA), 90% were treated within 24 hours against a target of 60%. For low risk patients, 84% were treated within seven days of first contact against a target of 60%. 12 month data showed that the target for low risk patients was nearly always exceeded whereas performance for high risk patients had been more variable.
- Mortality and morbidity meetings were held to review individual cases and identify any learning and action points.

Competent staff

- Staff received an induction prior to commencing work that included orientation to the ward and hospital and also included mandatory training.
- Staff received ongoing meetings with their manager or supervisor during their induction period. Staff we spoke with confirmed that they had received an induction when starting work.

- Supervision and appraisal rates varied from ward to ward but most had had an appraisal in the last year.
 Staff we spoke with told us that they had received appraisal in the last year.
- Staff told us they were supported to undertake additional training and take on new skills.
- Three staff on Oxborough ward told is that they did not always feel competent to look after patients requiring NIV. There were competency assessments forms in place for tracheostomy care and NIV but we did not see any that had been completed. We asked for information as to which staff had been deemed competent to care for such patients. On Oxborough ward nine out of 34 staff had received training for NIV at the time of our inspection (26%). Of the 34 staff, nine were newly recruited and all but five had training booked before the end of the year. 54% had received tracheostomy training. On MAU only two out of 23 staff (8.6%) had received training for NIV however all remaining staff had training dates booked before the end of the year, five staff had received tracheostomy training. On the stroke ward nine out of ten staff had received training in tracheostomy care between April 2014 and May 2015.
- Outreach staff we spoke with told us they were regularly called to support staff caring for tracheostomy and NIV patients as staff requested the assistance and that the ear, nose and throat (ENT) specialist nurses supported the patients with tracheostomy. The outreach service was to become a 24 hour service by September 2015.
- Senior directorate staff told us they were aware of the skill mix concerns on Oxborough ward and had taken steps to address it including an uplift in staff numbers.
- Junior doctors also told us that they received little training when caring for patients requiring NIV and learnt from experience.
- In some other areas competency assessments were in place for some clinical skills such as central line care.
- Staff we spoke with told us they had been supported to undertake further education and training such as NVQ's. Six staff on a professional register told us that they were supported to maintain their professional registration through courses, training and supervision.
- Senior cardiology staff worked at a local cardiothoracic hospital to maintain and develop skills.
- There was a clinical educator in some areas, supporting staff and developing the skill mix. A clinical educator was due to start on Oxborough ward in the near future.

The clinical educator had undertaken significant work to ensure new staff were equipped to work on the MAU. This included "Spanish nurse survival guide to the MAU" which staff told us had been beneficial to their new role.

Multi-disciplinary working

- There was effective multidisciplinary working. Ward teams consisted of doctors, nurses, physiotherapists, occupational therapist and dieticians and other allied health and social care professionals.
- The team spoke to each other with genuine respect and appeared to have a good working relationship.
- We observed an MDT meeting that planned clearly the care of the patients discussed whilst seeking input from all members of the MDT. This ensured a holistic and consistent care plan was created.
- There were external MDT's in place for some conditions including haematology and cancers. This provided external challenge to plans of care and ensured consistency in treatment.
- Medical notes were used by all members of the multidisciplinary team to ensure effective communication.
- One complex discharge had included all members of the MDT and also mental health colleagues from a neighbouring trust to ensure a safe and timely discharge with a full care plan.

Seven day services

- There was a medical rota to cover the medical wards out of hours and weekends.
- Physiotherapy and occupational therapy provided a seven day service to the wards with the physiotherapists providing an on call service out of hours to support patients primarily requiring chest physiotherapy.
- There was a radiology service seven days a week but this provided only urgent scans at weekends. Staff told us there were no issues in arranging urgent scans and diagnostic imaging out of hours.

Access to information

- All medical records were available to medical, nursing and allied health staff. Staff we spoke with told us they had no concerns in relation to accessing medical information required for patient care.
- Blood results and other tests were available via an electronic system. Staff said results were available in a timely way and were easy to access.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

- Patients gave their consent appropriately before any care or treatment was carried out. We observed, on several occasions, patients being asked their verbal consent before staff carried out minor procedures such as phlebotomy or giving an injection.
- Patients requiring a more major intervention signed a formal consent form prior to the treatment. Consent forms were appropriately completed and filed in the notes. Two patients we spoke with told us that they had been asked for their permission before staff carried out a procedure.
- Where there were concerns about a patients capacity to give consent, staff appropriately applied the mental capacity act. We saw two assessments completed that showed the appropriate professionals had undertaken the assessment and that a best interest decision had been made.
- Staff were aware of the deprivation of liberties safeguards. We saw one patient who had a DoLS in place. We saw that it had been appropriately completed and that authorisation was properly gained from the local authority. There was clear, regular review for the need for the deprecation of liberty.



Services were planned to meet the needs of local people. The MAU meant patients could be referred directly and not visit the emergency department. There were plans for a catheter lab to commence operation with support from a specialist trust. Referral to treatment times met national targets and there had been innovative work to reduce length of stays.

Admission to the stroke unit (within four hours) was failing to meet the 90% benchmark. There was effective discharge planning and services were responsive to people's needs including named consultants and availability of specialist equipment. Complaints were properly investigated and learning disseminated to staff.

Service planning and delivery to meet the needs of local people

- The medical assessment unit saw patients referred from the emergency department (ED) or referred directly from their GP. This meant that patients could be seen by a senior doctor and be fully assessed without the need to visit the emergency department. Patients with neutropaenic sepsis attended the MAU directly without attending the ED.
- Physiotherapists saw patients on the stroke unit over weekends. NICE guidance is that stroke patients should be seen within 72 hours by a physiotherapist, the majority of patients on the stroke unit were seen within 24 hours, though SSNAP data did not support this.
- One ward, Stanhoe, was able to reconfigure its bed base to a 12 bed isolation ward in response to changing needs, for example in the event of a large number of infectious patients.
- Plans were in place to commence a cardiac catheter lab at the trust for patients requiring urgent treatment. At the time of our inspection, these patients were transferred to a local specialist centre for this procedure.

Access and flow

- Last available referral to treatment time data (RTT) showed that the medical directorate was meeting the 90% target for March 2015 in general medicine and dermatology.
- Average length of stay for elective general medical patients was in line with the England average, slightly better than the England average for clinical haematology and worse than the England average for respiratory medicine at 7.2 days compared to an average of 3.5.
- Average length of stay for non-elective patients was better than the England average for all specialties with the exception of cardiology which was worse than the England average at 9.2 days compared to an average of 5.5 days.
- Some local, ward level initiatives had resulted in reduced length of stay for patients. For example, we saw data from Windsor Ward that length of stay had been reduced from 11.2 to 7.1 days. This had been achieved by increasing therapy input amongst other initiatives.
- The stroke unit kept two empty beds so they were able to admit emergencies in a timely way. However, audit

data provided by the trust indicated that a performance measure that was still not being achieved was the four hour admission to the stroke unit which was met 80% of the time against a target of 90%.

- We saw that on occasions, stroke patients who were past the acute stage of their illness were transferred to other wards to allow the admission of acute stroke patients. All transfers were discussed between medical and nursing staff before patients were agreed for transfer.
- There had been a reduction in the numbers of patients transferred late at night and also the number of patients outlying on different wards. This had been addressed partly by giving patients named consultants on the ward they were cared for.
- Clinical coordinators/ physicians assistants had been employed to coordinate the patient pathway and were important at planning and facilitating timely discharges.
- Discharge arrangements were routinely discussed at board rounds. Board rounds included senior medical staff, nursing and allied health professionals to ensure each patient had a plan for discharge.
- We also attended an MDT meeting which discussed patient's needs, plans for discharge and actively considered the wishes of the patient and their relatives and carers.

Meeting peoples individual needs

- There was a range of displays with information for patients on the wards and in clinical and public areas. These were usually relevant to the type of speciality and included information such as care and support after having a stroke and self-management of a range of conditions and diseases.
- The leaflets displayed were all written in English with very limited information available in languages other than English.
- Intentional rounding was carried out throughout the medical wards. Records indicated that the vast majority of rounds were completed. Staff ensured patients were comfortable and were observed to also ask if patients required pain relief.
- Patients were given a named consultant for their care. A number of the patients we spoke with were aware of who their consultant was.
- Interpretation services were available via Language Line. Staff told us that they seldom required it but were aware of how to access it when needed.

- Specialist equipment was available either through the equipment stores or by hiring equipment externally. Bariatric equipment had been hired for a patient and this had arrived within hours of its order.
- Some side rooms in Tilney ward had no windows. Patients in these rooms told us that did not know whether it was day or night in the rooms and they were unable to see the corridor or outside for stimulation. Staff told us that patients could be cared for in these side rooms for several days. Whilst staff left the room door open when they could this was not always possible.
- There was a newly refurbished ward that was designed specifically for care of people living with dementia. It was designed and decorated to ensure people remained orientated and had outdoor space. It was due to open shortly after our inspection.
- Patients who were at risk of falls were identified by a small red dot above their bed to alert staff to the risk.
- The meal supervisor/ support role played an important role in ensuring patients received timely help with eating their meals.

Learning from complaints and concerns

- Information was available around the medical wards about how to make a complaint or raise concerns.
 Information was also available for the patient advice and liaison service.
- The total number of complaints received by each medical ward was collated regularly for governance review in the medical directorate.
- We saw an example of a recent complaint. It had been investigated appropriately locally and that learning had been identified. The patient and their relatives had been offered a face to face meeting to discuss the issues and offer an apology.
- Feedback from learning from complaints was through staff meetings or on the cardiology ward, by a monthly newsletter.
- Staff we spoke with told us they had been made aware of recent complaints and any changes in practice that were related to it. They were confident about how to support people who wished to complain.

Are medical care services well-led?
Medical care (including older people's care)



The medicine directorate was well led as there was a clear vision for the service as well as detailed strategic plans for the development of services however we found that not all staff were fully aware of them. There was a robust ward to board governance structure and we saw that senior managers had a clear idea of the risks within the directorate.

Staff spoke highly of the leadership of the service and senior directorate managers felt well supported by the new substantive board members. All staff we asked told us there had been a positive shift in culture under the new leadership, staff felt supported and able to raise concerns. There were detailed plans for service development and improvement.

Vision and strategy for this service

- There was a clear vision for the service and how it would function through an integrated health economy. Staff we spoke with were aware of the corporate vision of the trust.
- There were advanced plans in place for the creation of a higher dependency area within the respiratory ward to cater for patients requiring NIV, tracheostomy care and more intensive respiratory support. This meant the reconfiguration of the ward to support this new service.
- Plans were in place to commence primary percutaneous coronary intervention (PPCI) at the trust for patients requiring urgent treatment. At the time of our inspection, these patients were transferred to a local specialist centre for this procedure. Detailed plans included clinical support whilst the service was established and the on-going training of staff and the identification of new facilities.
- Some wards had their own 'Vision of excellence', identifying what they achieved well and areas for development on the ward. Two staff we spoke with on these wards knew of their ward vision.

Governance, risk management and quality measurement

• Clinical governance meetings were held within the directorate and also at ward level, with the ward level meetings leading to the directorate meeting. This ward

to board governance structure was implemented in early 2015. Minutes of these meetings showed risks and concerns were discussed and any incidents occurring within the directorate. They also showed good attendance by key clinical staff.

- There was a risk register in place for the medical directorate. Risks had been identified and appropriate dates given to address or mitigate the risks.
- Senior ward staff told us they knew how to escalate concerns to senior directorate management. One member of staff we spoke with told us how they were supported to put an item on the risk register.
- We reviewed the action plan for the medical directorate following the inspection in 2014. We saw that almost all risks identified had been fully addressed and mitigation identified.

Leadership of service

- All of the staff we spoke with said they felt supported by their line-managers and staff told us they felt supported by their directorate managers and lead nurses. One senior member of staff said they felt supported by their matron but had had three matrons in the last six months with a resulting lack of continuity.
- Staff spoke highly of the new chief executive. Junior ward staff to senior management told us the benefit of having a board that was now substantive. In 2014 a significant number of key roles were interim appointments.
- Staff told us that executive leadership was visible and approachable.
- The clinical and managerial leads were clearly passionate about the changes they were making to the medical services and how much had been achieved since the previous inspection.
- The stroke ward had an enthusiastic ward manager in post who staff spoke highly of but it had taken many months to make an appointment into this position.
- The staff on Stanhoe ward were particularly positive about their ward manager and local leadership.

Culture within the service

• There was a positive, open culture in the service. Staff told us they were able to raise concerns internally and that they felt listened to.

Medical care (including older people's care)

- There was a clear understanding of the challenging journey that the directorate and trust had been on in the preceding years but a there was a real optimism about the changes made so far and plans for the future.
- All staff we spoke with spoke positively about the team ethos in their department.
- Senior directorate management praised the new directors for listening and being actively involved with the directorate.

Public and staff engagement

- When staff left the trust, exit interviews were conducted to identify any underlying trends into why staff were leaving. Actions had been identified in relation to this, such as the provision of additional training in order to retain staff.
- On the stroke ward, patient and family feedback indicated that they were unaware that there was a dayroom on the ward. Ward staff had improved communication so patients and relatives were aware of it.
- Staff who were to work on the new ward for patients living with dementia were encouraged to be involved with the design of the ward, layout and how teams would work in the new environment.

- The trust distributed 'The Knowledge', a weekly newsletter to staff which included important information, compliments, items from the news and updates on changes at the hospital.
- Senior directorate staff told us that the consultants were fully informed about the introduction of the acute respiratory bay on Oxborough ward, however we found that senior medical staff seemed unclear and inconsistent about how the unit would function.

Innovation, improvement and sustainability

- There was a credible plan for moving the service forward and developing new services and making use of technology.
- The directorate was planning new services including the use of PPCI at the trust and the development of a dedicated bay in the respiratory ward for patients requiring additional levels of care.
- We were aware there were plans in place for a virtual ward for patients awaiting care packages with short term support provided to patients at home.

Responsive	Good	
Well-led	Good	
Overall	Good	

Information about the service

The surgery services at the Queen Elizabeth Hospital are divided into three divisions: specialist surgical services group, theatre services group and surgical services group. The surgical services group included general surgery, elective and trauma orthopaedics, plastics, surgical assessment unit (SAU) and four surgical wards. The specialist surgical services group included ophthalmology, ear, nose and throat (ENT), oral surgery, orthodontics, urology and dermatology and the theatre services group included main theatres and day surgery, endoscopy, pain management, anaesthetics, pre- assessment and sterile services.

There are several areas within the service which are designed to improve patient access and flow through the hospital and allow flexibility in service provision. The surgical admissions unit (SAU) is situated on Leverington ward and has an additional escalation area that can be utilised for medical outliers and emergency admissions. Marham Ward is an admission and discharge ward. Patients can be transferred onto Marham to await discharge thus giving additional flexibility and increase the availability of beds. The treatment investigation unit (TIU) on Feltwell ward facilitates interventions such as biopsies, transfusions, diagnosis and on-going treatments on an outpatient basis and thus avoids unnecessary admissions.

In our previous inspection in July 2014 eight surgical areas, including theatre were visited, 20 patient records were reviewed, 28 patients and 40 staff were spoken to.

In 2015 we visited all eight of the surgical areas including endoscopy, theatres and day surgery. We spoke with 38 staff, including medical and nursing staff, 11 patients and three relatives. We also reviewed eight sets of medical records and information requested by us and provided from the Trust.

Summary of findings

In 2014 surgical services were rated as good for safe, effective and caring and inadequate for responsiveness and requires improvement for well led.

During the inspection in 2015 we reviewed responsiveness and well led aspects of patient care within surgery. There had been considerable improvements, the responsiveness of the service was good and the service was well led. There had been a dedicated focus on improving the efficiency of the service. Whilst cancelled operation total numbers remained high there was a downward trend emerging and an improving performance on patient booked within 28 days

Identified specialties for further improvement were trauma and orthopaedics and urology. Timely admission for patients with fractured neck of femur was not consistent and there was no robust system to ensure patients were seen in a timely manner for urology. Feltwell ward (Urology) had no ward manager in position with clinical specialists undertaking dual roles. Staff had raised concerns that this situation was not sustainable and that there was limited risk management and oversight which could become detrimental to patient safety. There was no tracking system in place to record the decontamination of flexible cystoscopes used with urology. The on call consultant cover for Endoscopy required review as there was no formal medical consultant on call rota to cover for emergency gastric bleeds.

Are surgery services responsive?

Good

In 2014 surgery services were not responsive to the needs of patients and were rated as required improvement. This was due to service planning, admissions the day before surgery and a high number of patient cancellations on the day of surgery. There were also concerns identified with privacy and dignity provision of patients attending breast care.

During our inspection in 2015 there had been a focus on improving responsiveness within surgery. Total numbers of cancelled operations were improving through several initiatives undertaken by the trust. This alongside an improving performance on patients rebooked within 28 days increased the trusts responsiveness to patients. Patients we spoke with confirmed that the time between referral and treatment had been shorter than they expected and were impressed with the care.

The location of the breast care unit had remained the same as previously and therefore issues with providing privacy and dignity for patients were ongoing. Plans had been agreed for this service to move location within the next six months although the actual date was yet to be finalised. The relocation will increase the imaging provision and improve the facilities which will enable staff to provide care to patients and maintain privacy and dignity.

The patient pathway for orthopaedic patients with fractured neck of femur needs to be improved and there was no robust system in place to ensure the timely management of urology patients. Additional training for staff regarding care for patients living with dementia was required.

Service planning and delivery to meet the needs of local people

 There was a downward (improving) trend from quarter one (April to June 2014) through to quarter four (January to March 2015) with cancelled numbers being 116, 89, 85, and 55 respectively. Alongside this there was an improving performance on patients rebooked within 28 days (73%, 65%, 80%, and 93%). The downward trend was interrupted in April to May 2015 when the trust had a high number of cancellations (78) however the readmission rate within 28 days for the same period was 91%. Reasons behind the increase included unexpected urology staffing problems when a locum consultant failed to arrive which led to cancellation of day surgery patients, equipment issues with urology lasers and 20 of the cancellation in early April were due to bed pressures. A new laser for urology had been commissioned to prevent delays in treatment.

- The trust had several initiatives to focus and reduce cancellations and had been proactive in the management and planning or elective surgery. This included booking day cases and paediatric cases to main theatre lists during periods of high pressure on beds, improved planning and flexible use of resource within main theatre and improved use of virtual ward for elective day cases, this is for patients who would otherwise require an inpatient bed because they have no overnight carer. Staff in the day surgery unit (DSU) also review the inpatient list and identify patients that could potentially be recovered in DSU and go home the same day following discussion and agreement with the patient, surgeon and anaesthetist.
- The breakdown of reasons for cancellations included lack of theatre time, equipment not available, staff shortages and lack of high dependency or intensive care unit beds. The highest percentage of cancellations remained the lack of available ward beds however there had been improvement with a 58% decrease in the six months October 14 to March 15 in comparison to the previous six months (April 14 to September 14).
- Cancellations on the day were normally attributed to patients not being clinically fit for surgery. Staff within main theatres stated that cancellations were becoming rare. A senior member of the team stated that when cancellations did occur, on the day of surgery, the theatre coordinator would liaise directly with the bookings manager to reschedule the operation. This meant that patients were informed of the rescheduled date for surgery at the time of cancellation.
- The location and layout of the breast care unit remained as it was in 2014. Patients were still required to cross a corridor for scans; space was limited with small consulting rooms and no dedicated area for private conversations following diagnosis. Ensuring privacy and dignity remained an issue as nurses were often required to hold difficult conversations and provide support behind a curtained area which was shared with the ultrasound department

 Staff informed us that the lack of space on results day, which tended to be busier, made it especially difficult to find appropriate areas to have private conversations. It had been confirmed that the unit would be moving into the area currently used by genito-urinary medicine (GUM).Staff stated that this should be within the next six months however there was no finalised date at the time of our inspection. The GUM area will provide adequate space for all aspects of the breast care service, including separate rooms for counselling and prosthesis fitting. Imaging capabilities will be increased with an additional ultrasound and staff were excited by the prospect of providing a bespoke service.

Access and flow

- On Gayton orthopaedic ward, there was only one bed ring fenced as an emergency bed. This was identified as an area for improvement by the staff and was identified on the vision poster on the ward. Part of the trauma nurses role was to liaise with medical and nursing staff regarding appropriate care when there were orthopaedic outlier patients on non-surgical wards.
- Improvement had been made to achieve referral to treatment within the 18 week target. Data provided from the trust indicated that the target of 90% had been reached in January and February 2015 (93.5% and 92% respectively). Latest figures for May 2015 show that in general surgery the referral to treatment times were above the national standard at 96%.
- Admission of patients from day surgery to inpatient wards was monitored and recorded. Data showed that the Trust target of 1% for patients admitted as day surgery cases who required overnight admission was achieved in the first quarter of 2015. Numbers were 0.47%, 0.79% and 0.32% for the months of March, April and May 2015 respectively.
- Admission the night before surgery occurred only when there was a clinical need, for example frail or elderly patients that were due to undergo bowel surgery and needed assistance with bowel preparation.
- Two patients informed us that they had received timely and responsive care and had shorter waiting times than expected for clinic appointments and for treatment.
- On Denver ward there was a specialist patient flow sister who worked Monday to Friday between 8am and 4pm. This role was unique to this ward and the purpose was to try to improve the patient experience and ensure the patient pathway was followed. This role also included

daily updates to the patients and relatives and liaison with community services. There was no formal audit of the success of this role, the member of staff said that they self-audited. By managing to carryout local ward resolution for complaints they were confident that there had been a reduction in complaints and an improvement in the friends and family test (FFT) survey. Data from 2014 showed that the FFT scores for Denver ward remained consistent with the average 88% willing to recommend. Average scores for Elm ward, Gayton ward and Leverington ward were 91.5%, 87% and 89% respectively.

- There were four medical outliers on Denver ward at the time of our inspection. Review by medical staff of medical patients on surgical wards was undertaken by a named consultant. This meant medical patients on surgical wards had daily review by medical staff and nursing staff were aware of the correct person to contact. The name of the identified doctor was displayed on the ward 'white board' along with contact details. Each patient had an identified consultant, registrar and house officer and nursing staff confirmed that normally when bleeped the team would respond in a timely manner (hospital standard response was 10 minutes).
- The surgical admissions unit (SAU) is situated on Leverington ward and had an additional escalation area that was utilised for medical outliers and emergency admissions. Patients awaiting medication can be discharged to the discharge lounge which was situated in Bay 4 and 5 in Marham ward.
- General themes for delayed discharges were delays with equipment delivery, such as specialist bed, hoist, mattress etc. delays with the arrangement of care packages, or limited availability of beds with ongoing care providers.
- Feltwell ward was divided between Urology patients and the treatment investigation unit (TIU). The purpose of the TIU was to facilitate interventions such as biopsies, transfusions, diagnosis and ongoing treatments on an outpatient basis. This was good practice as it avoided admission, was beneficial to the patients and aided the overall bed situation within the trust.
- There was no robust system to ensure patients were seen in a timely manner for urology. Staff were concerned that as the workload increased the risk of delay to treatment would increase and were not

assured that the situation was sustainable. At the time of our inspection, staff stated cystoscopy clinics were one month behind schedule and staff were not aware of a plan in place to address this. Data provided by the trust showed that there were 93 patients waiting for cystoscopy and out of a total of 441 patients, 61% had been seen within six weeks of referral and 3% (15) of patients had waited over 18 weeks.

- There were weekly cystoscopy clinics undertaken however the nursing staff had no access to review timescale breeches in advance and there was no alert mechanism to flag if a cancer patient had been cancelled. This meant the staff could only be reactive rather than proactive in managing clinics. Additional adhoc urology clinics, such as evenings and Saturdays, were arranged as necessary to prevent patient breaches. The band seven specialist nurse was "keeping an eye" on the waiting list.
- We were informed that the urology schedule often changed and that the ward receptionist would ring patients and rearrange appointments accordingly. This was time consuming as there could be as many as 20 changes in a morning.
- Endoscopy ran four routine lists per day and there was a two week wait for treatment. Two weeks prior to our inspection there had been a staff skill mix review against utilisation that demonstrated current staffing would provide 80% utilisation. There was no formal medical consultant on call rota to cover for emergency gastric bleeds; this was being covered by goodwill which meant that we could not be assured that this would be sustainable. This had been discussed and documented at the Theatre standards quality and business board (SQaBB) in April 2015 with the action to take to divisional board and place on risk register.
- The breast care unit provided triple assessments, which provided consultation, scan and biopsy if necessary, on the same day. This meant that patients benefitted from having all tests undertaken immediately and results could be obtained in a timely manner and the stress of the process was not overly prolonged.
- There was a nurse led pre-assessment unit based on Westerom ward. Access was varied with some delay to appointments taking up to eight weeks. However there were urgent appointments available for patients on the cancer two week wait pathway. Patients informed us that there was some difficulty in finding pre-assessment

as signage could be improved. Patients were assessed for fitness for surgery and a consultant anaesthetist was available on call to come to Westerom ward and complete a risk assessment for a patient when required.

Meeting people's individual needs

- There was a system for identifying individual need on the productive ward white boards. There was a daily multidisciplinary team (MDT) meeting held to plan care and to feedback and update on patients' needs.
 Different coloured magnets were used to identify specified needs. For example a red dot indicated a risk of falls, a blue dot indicated assistance with feeding was required and a flower identified patients living with dementia. This meant that staff could easily identify different patient needs.
- Occupational therapists (OT) and physiotherapists worked closely as part of the multidisciplinary team on the surgery wards. A member of therapy staff informed us that communication was good and the rapid assessment team, in the emergency department, passed on information regarding patients that required admission. The therapy team assess the patients' ability to return home following surgery. These assessments included both personal activities and domestic activities. If a patient lives alone occasionally the OT staff carried out discharge home visits to ensure that the patient was settled in their own home.
- Some wards had been adapted for patients living with dementia. For example on Gayton ward, orthopaedics and trauma, there was dementia friendly signage showing directions to toilets and showers and red raised toilet seats in situ which was good practice for people living with dementia.
- However staff understanding of patient's living with dementia needs was varied. One ward manager stated that they did not have any patients with cognitive deficits at the time of inspection however there was a clearly confused patient on the ward. When we reviewed the patient notes it had been documented that delirium was the possible cause of the confusion and assessment had been completed. The patient was also described in the notes as 'a wanderer' which was a term that lacked dignity and respect for the patient.
- We were not assured that staff training for caring for patients living with dementia was effective in practice.
 Data indicated a high percentage of staff within surgery had received training however staff identified the need

for additional training in care for patients living with dementia and completing capacity assessments. On Denver ward a team member had been identified as a dementia lead and was due to undertake advance training and would then disseminate information to the wider team. Staff were aware of the new dementia friendly ward that was due to open on 22nd July 2015.

- There were patient passports used for patients living with dementia where information was gathered from relatives and the patient as to background information and what was normal activity for the individual. However we reviewed six sets of patient nursing notes and the passport was not completed in any we sampled. We were unable to determine whether the document was established in practice from the point of staff being able to identify a patient with cognitive deficit, and then recognise the need for this information/document.
- Nursing staff on Feltwell ward (urology) provided a direct telephone number for patients to enable them to contact staff directly with any queries. One patient we spoke with confirmed that he had the contact details of the specialist nurse and was happy to contact her if required in-between clinics
- The trust had a face to face and remote (accessed via telephone) translator service and staff were aware of how to access this service.
- Appointment letters for Endoscopy were provided in other languages, such as Russian, Polish and Portuguese. Information leaflets were comprehensive and easy to read, however these were not provided in different languages.
- The trust has an action plan in place for paediatric facilities in DSU and main theatres to ensure compliance with current national recommendations and Regulations. Each action has been rated using a red, amber, green system to identify severity of risk. The security of the environment has been rated red for DSU as the bay where children are cared for has open access. Parents are advised to stay with children at all times and a business plan was underway to explore the cost of CCTV and a swipe access system. This is due to be delivered to the theatre standards quality and business board (SQaBB) meeting in July 2015.

Learning from complaints and concerns

- Patients informed us that they felt that the service was good and that they had no concerns or complaints.
 Patients were aware that complaints could be raised through the patient advice and liaison service (PALS) office within the hospital.
- Ward managers attended a monthly key learning and actions group at which never events, complaints, policy changes, risks and implementing changes required following incidents and serious events are discussed. Information is disseminated to the ward staff via email, communication books and notice boards to ensure that learning is widespread and this was confirmed by staff. On Gayton ward there was a newsletter produced for staff on alternate months which provided similar information.
- On Denver ward an issue had been identified involving expired medication on the medication trolley. The ward manager met with all qualified staff and explained the issue and consequences. Following which random checks were carried out. If any out of date medications were found the individual responsible had to remedy the situation prior to their shift ending. This encouraged staff to have ownership and learn from incidents.

Are surgery services well-led?

Good

Our inspection in 2014 had identified concerns with communication between clinical leads, elective and emergency teams and governance arrangements. At our inspection in 2015 significant improvements had been made . There was an operational management structure in place from June 2015 and the surgery service had been divided into the three surgical service groups, each with a matron and clinical audit facilitator in place. However not all staff were aware of which service group their area sat under which meant that management structure was not always clear to the staff at ward level.

The leadership within the surgery service reflected the trusts vision and ward managers were given the autonomy to manage their own areas. In the majority of areas staff felt supported at a local level. Specialist nurses were acting in a

dual role which was not sustainable and whilst patient care had not yet been affected there was limited risk management and oversight which could become detrimental to patient safety.

Vision and strategy for this service

- Staff felt that the trust had improved services and morale during the past year. We were informed on a number of occasions that this was specifically driven from the chief executive officer (CEO). There had been increased nursing numbers across the trust, improved communication and improved peer and team support and investment in new equipment, such as decontamination and stack systems in endoscopy that had helped improve staff morale.
- There was a trust wide vision and strategy which had been communicated and displayed throughout the hospital. There were laminated vision posters on the surgery wards that identified "the big six" which were three areas of pride and three areas to improve specific to that individual ward.
- There was an elective division strategy and vision (May 2015) that encompassed the trusts vision and strategy. This identified divisional objectives alongside potential risks to delivery. There were clear core strategic aims for the next three years alongside identified priority developments for each specialty.
- Staff were aware of the trust vision and received regular communication via email and the weekly magazine.

Governance, risk management and quality measurement

- There was an identified governance structure within the surgery division. Quality governance was monitored through individual standards quality and business board (SQaBB) meetings that reported to each core divisional board performance group which then reported into the trust clinical governance committee. Risk was reported from each SQaBB to the trust risk committee and operational performance was reported from the SQaBB to the trust executive committee.
- Minutes of the monthly SQaBB meetings evidenced that there was regular governance review, including review of clinical outcomes, standards and benchmarking, review of serious incidents and never events, risk and performance updates.
- Following incidents there was a documented process of reporting, root cause analysis investigation and

outcomes identified. There was communication and reporting through the governance structure to board level following incidents. For example there had been a recent incident regarding a national shortage of medication required for treatment of bladder cancer. This had been raised as a risk, recorded on the trust risk register and all patients were contacted and kept informed of possible delays.

- The level of ownership of risk management on various wards was inconsistent. Most wards had a system in place to disseminate information to front line staff however on Feltwell ward there was minimal oversight.
- There was a clinical audit facilitator attached to each of the three surgery services groups. On Elm ward the audit plans were documented on the white board in the ward managers' office. Action plans were in place for any audits that missed the benchmark, for example the fluid chart audit, which had been identified, actions taken and re-audit scheduled for the following month.
- Staff informed us that complaints and incidents were discussed at monthly specialist nurse meetings. We found that the minutes from these meetings were not extensive and from the three months we reviewed attendance was limited (with the average attendees amounting to three), no specific incidents or risks had been discussed and no regular heading for governance.
- Patient complaints and feedback were discussed and documented as part of the monthly individual specialty governance meetings.
- On Feltwell ward the flexible cystoscopes were decontaminated using a three step process in line with national guidance and single use sterile sleeve was in use. However there was no audit record of decontamination which meant that full traceability could not be provided which does not comply with national standards. This was brought to the attention of staff who informed us that they were aware of this gap having recently attended a neighbouring trust which had a traceability system.

Leadership of service

• Leadership at a local level was good with the majority of staff confirming that their line manager and matrons were approachable, responsive and involved staff in the ward development. On Denver ward staff said that this went towards staff retention and made them want to stay.

- The CEO held weekly open door Friday meetings that staff were aware of however the majority of staff we spoke with said that due to clinical need they had not had the opportunity to attend.
- Ward managers stated that matrons were visible however they were given autonomy to manage their own ward areas. We were informed that the associate chief nurse had a clinical day on a Friday and was present on the wards.
- The two band seven clinical specialists nurses on Feltwell ward were carrying out the manager's role. Staff informed us that no funding had been included in the business case for the appointment of a ward manager. Due to clinical commitments and the priority of their patient facing roles, the management tasks and compliance requirements were found to be lacking. The clinical specialist nurses had raised their concerns regarding the unsustainability of the situation with their line manager however there has been no action taken to address this. The clinical specialists had not been involved in the transformation meetings regarding the service they were providing. This was rectified only when they approached the CEO directly following which they have attended meetings and been involved in planning and discussions.
- There was confusion among staff on Feltwell ward as to which directorate they sat under. Staff thought the service was now classed as an outpatient service and no longer remained part of the surgery division. Urology sits within the specialist surgical services group but staff were not aware of this.

Culture within the service

- There was a positive culture within the hospital. Staff felt supported and were aware of how to raise concerns and how to access the whistleblowing policy. One member of staff said that they
- "used to be ashamed to say where I worked at QEKL but this is now improving I am happy to say where I work."
- The collaborative learning in practice (CLIP) process had been introduced in November 2014. This was a competency based learning where support was provided by qualified staff and had initially been to support junior, overseas and student nurses. One student informed us that this was assisting her to become more independent, confident and competent.

They had been allocated a mentor on each shift to work alongside and they were very positive about this method of learning. The CLIP learning log included goals, student reflection and coach feedback.

• Some healthcare assistants informed us that there had been some segregation between the qualified staff and the unqualified staff, however this was improving and the CLIP seemed to be helping with this.

Public and staff engagement

- All staff had equal opportunity for training and development. Apprenticeships through the Open University were offered and we spoke with two healthcare assistants who were due to take up this opportunity, which was part funded by the trust.
- Within the surgery division there was evidence that nursing staff were encouraged to engage with developments. For example staff within the breast unit felt that they were included in the plans to move to new premises. Planning meetings had begun which included the lead nurse and they felt that they "had a voice". We were informed that as a group the band seven nurses raised the suggestion of a nursing pool to address short notice staffing pressures when sickness occurred. This had been implemented and there were approximately four staff daily allocated as "pool" from the bank who were not assigned to any specific ward. These staff report to the operations centre at the beginning of the shift and are then allocated accordingly to areas in most need that day.
- There was a "patient nomination for shining stars" award recognition scheme where patients could vote for staff that had a significant impact on them. We spoke with two staff who had been nominated and they confirmed the nomination had added importance as it came from the patients.
- There was a visioning group which was consultant led and attended by the associate chief nurse and senior staff. The aim of this group is to enable staff to have input in ideas to improve services. Staff were positive about this however this was still in the early stages of development and the group had only met once at the time of our inspection.

Innovation, improvement and sustainability

- There were plans in place to move the prostate clinic (biopsy review) up to Feltwell in September 2015 which would assist with the patient pathway for urology.
- There had been investment in central decontamination and there was a new central sterilising unit where all flexible endoscopes were processed from main theatres and endoscopy. This new system provided a lengthy decontaminated period (100 days) for scopes and complete traceability which improved efficiency to services as it reduced delay for patients waiting for

equipment to be processed and provided increased safety for patients. This process did not extend to the flexible cystoscopes in use in Feltwell ward at time of our inspection.

• Refurbishment of two theatres within main theatres has been approved and at the time of our inspection one theatre was closed as refurbishment had started. The tunnel washer within the central sterile services department was due to be replaced in the first week of August 2015.

Responsive

Well-led

Overall

Information about the service

The Trust provides maternity services to the populations of West Norfolk, East Cambridgeshire and South Lincolnshire. Services are provided in women's homes by the community midwifery team and outreach clinics are held in Wisbech in Cambridgeshire and Fakenham in Norfolk.

The maternity service included a delivery suite, a combined ante and postnatal ward, an antenatal clinic and a day assessment unit. There is also a level two neonatal intensive care service which has a total of ten cots. Together these facilities provide care throughout the antenatal, intrapartum and postnatal period.

The service previously provided a home birth service but this was suspended in September 2013 and had not recommenced when we inspected. The infertility service transferred to Bourne Hall Clinic in Cambridge in 2014. There were 2,240 deliveries between July 2013 and June 2014. The Trust is in the lower quartile for number of deliveries compared to other trusts. The Trust had a higher percentage of births to mothers aged 20-34 (80% compared to England average of 76.1 %)

Summary of findings

In 2015 both responsive and well led in maternity services required improvement. Many of the issues we identified in maternity services during our last inspection in 2014 report had not improved. Staffing both medical and nursing was a concern, specifically senior medical staffing, and midwifery staffing levels meant staff had to be transferred from other areas of the service to support the central delivery suite (CDS. At times the unit had to close due to insufficient numbers of staff with patients being diverted to other units.

Women who used the maternity service at the Queen Elizabeth Hospital were not offered the choice between a home birth or a birth in a midwifery led unit. The water pool room had been refurbished in April 2014 and increased staffing levels meant more women were offered the choice of a water birth. The Trust had developed plans for a midwifery led unit and aimed to have the service in place by September 2015.

Planned elective caesarean sections were delayed on occasions because of theatre and medical staff availability. Patient assessments were not consistently recorded which meant there was a risk that a woman's deteriorating condition may not be escalated appropriately. There were privacy and dignity concerns for women experiencing a miscarriage as they were seen in the main emergency department or the surgical assessment unit before being admitted to a surgical ward.

The trust had commissioned a review by the Royal College of Obstetricians to look at the leadership and management of the service. The review highlighted the lack of clinical outcome information and the absence of outcome reviews. There was a lack of clinical ownership

Requires improvement

Requires improvement

Requires improvement

for clinics, inpatients and theatre lists. The report had been submitted to the trust in April 2015 but it was not clear what the trust's plan was for responding to the recommendations.

There had been a change in leadership with the head of midwifery stepping down and a new clinical director appointed. A maternity transformation project was in the early stages of development but it was not clear whether consultant medical staff were fully engaged in the work. A strategy for quality improvement across the trust had been developed and strategic objectives had been identified at specialty level however a strategy for maternity services had not been developed.

Are maternity and gynaecology services responsive?

Requires improvement

The responsiveness of the maternity and family planning service required improvement. Women who used the maternity service at the Queen Elizabeth Hospital were not offered the choice between a home birth or a birth in a midwifery led unit. The Trust had developed plans for a midwifery led unit and aimed to have the service in place by September 2015.

Planned elective caesarean sections were delayed on occasions because of theatre and medical staff availability. There was one dedicated theatre allocated for obstetrics and the procedure was undertaken by medical staff who were also on call for emergencies within the obstetrics and gynaecology service which meant they could be called away to deal with emergencies.

The service had responded to the needs of families from eastern Europe by providing parent education classes with translators who could speak Latvian, Russian, Polish and Lithuanian.

Women who attended the emergency department (ED) because they were experiencing a miscarriage were seen in the main emergency department and if they required inpatient care they were seen in the surgical assessment unit before being admitted to a surgical ward. There were no arrangements in place to protect their privacy and dignity.

Service planning and delivery to meet the needs of local people

- Bed Occupancy was analysed for April 2013 to September 2014 Bed occupancy was high ranging between 79% and 83% each quarter (compared to England averages of between 55% - 60%).
- The staff understood the needs of the population who used the service and had developed plans for developing the service for example the midwifery led unit .The service had worked with the local maternity liaison committee to develop plans for the service.

- A 'time to talk' service had been introduced to support women who had previously had complications of pregnancy. Women were referred to discuss mode of delivery. We spoke to one person who told us they found this helpful in allaying any past concerns.
- The water pool room had been refurbished in April 2014 and increased staffing levels meant more women were offered the choice of a water birth. The service was able to support women with a water birth depending upon the number of women who wanted to use the facility and adequate staff being available. Women discussed their preferences for delivery which enabled staff to plan some water births.
- There was no home birth service or midwifery led service available to women. The home birth service had been suspended in November 2013 because of staffing regulations which required changes to the staffing structures. The Trust had received 17 comments and complaints about the lack of a home birth service since 2013. A business case was being developed for a night time service but there were no immediate plans to re-instate the service. Discussions had been held with local groups of service users however the Trust had not undertaken a formal consultation to obtain the views of the local population. Midwifery managers told us the development of a home birthing service was a priority for midwives but there was no plan to reinstate the service in the immediate future.
- Plans were being developed to create a midwifery led unit for women with low risk pregnancies. Part of the central delivery suite would be re-developed to provide three birthing rooms. The head of midwifery told us they hoped the new unit would be open by September 2015.

Access and flow

 The care of women experiencing a miscarriage or ectopic pregnancy was provided by the surgical directorate. Staff on the surgical assessment unit told us the facilities were limited and there was often a delay whilst patients waited for medical review. When a woman needed to be admitted there were no specifically identified wards for gynaecology patients. This meant that any available surgical bed may be used and in some areas staff were unlikely to have any gynaecology experience. To help mitigate this staff attempted to allocate women together but it was not always possible. There were no facilities in the accident and emergency department for women who were miscarrying. This was a longstanding problem which had not been resolved.

- The service's escalation policy was used on 34 occasions during the period February to May 2015 which had resulted in closure of the central delivery suite on five occasions and closure of the day assessment unit. The closure time varied depending on the specific situation with the longest period being 27 hours. The main reason for this was due to insufficient staffing levels on the central delivery suite. When this occurred staff were re-deployed from other areas or the suite was closed which meant women had to be transferred to other units
- In the period April 2014 to March 2015 there were 217 incidents reported relating to staffing levels within the service. Incident reporting over the last six months showed the highest number of incidents reported related to inadequate staffing. The trust board received a paper in May 2015 on staffing and skill mix which stated midwifery staffing levels needed to be increased to meet best practice standards. The trust was not planning to increase staffing levels but planned to modernise the service including re-organising midwifery staff.
- We reviewed the incidents reported for the maternity service from February 2015 to May 2015 which contained reports about the closure of the central delivery suited. The report showed the longest period the central delivery suite had closed was 27 hours from 9.30am 30th May 2015 until 1pm on 31st May 2015. Central delivery suite closures as a result of insufficient staffing were reported on the trusts incident reporting system. However, the length of time the central delivery suite was closed was not always clearly recorded. We saw examples of incidents women had been transferred to another unit but it was not clear if the details of transfers were always recorded.
- The service's risk register stated midwifery and support worker staffing levels were to be reviewed to ensure they met patient needs. A paper presented to the trust Board in May 2015 stated that an additional 2.2 posts and additional on call capacity at night had been created to accommodate changes in the level of need on the central delivery suite. The paper stated this had led to a reduced number of closures in 2015 compared with the same period in 2014. However, the trust were not able to

meet the staffing levels recommended by the Royal College of Midwives based on the staffing tool birthrate plus which is endorsed by the college,. The director of nursing and midwifery stated the service required modernisation as well as additional staffing to improve the service.

Meeting people's individual needs

- 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.
- Teams of community midwives and maternity care assistants provided antenatal and postnatal care in women's homes at other providers and in GP surgeries for women who had difficulty travelling to Kings Lynn.
- The service had responded to the needs of families from Eastern Europe by providing parent education classes with translators who could speak Latvian, Russian, Polish and Lithuanian. This meant women whose first language was not English were able to access information which they were able to understand. Two midwives were responsible for working with vulnerable women. This included women with a learning disability, mental health issues, substance misuse issues and teenage pregnancies.
- The service carried out two planned caesarean sections per day. On occasion this would rise to three if a woman was referred from clinic. There was only one theatre in the delivery suite. There was access to a theatre in the main operating department if two women required a caesarean section at the same time but this did not happen in practice. Elective caesarean sections were carried out by the on-call medical team who were not always available to carry out the procedure when planned. This meant that women booked for an elective caesarean section could be delayed, because emergency caesarean sections and other emergencies took priority. Staff informed us that they were in the process of analysing the cases which had been re-scheduled to identify any changes that could be made, for example alterations to medical cover, to reduce the number of re-scheduled case
- The governance group had discussed the situation in January 2015 and agreed a solution was required as a matter of urgency. However, the matter had not been resolved when we inspected in June 2015 therefore we were not assured that this was being managed in a

timely manner. We reviewed the service's risk register and saw this had not been included as a risk. However, staff told us it was important the matter was resolved to provide women with an effective service.

- The early pregnancy assessment unit operated from 8am until 5pm from Monday to Friday and by appointment on Saturday mornings. Women were referred to this unit by their midwife or GP. The number of women attending the unit had doubled over the last 12 months. One patient told us they had to wait for a long time to be seen by medical staff.
- One consultant with input from a specialist nurse saw women with diabetes. However there was no clear pathway for women with other medical complications. Other high risk pregnancies were looked after by all the consultants rather than focussing time and expertise in specific clinics for example for twins or small babies. This meant there were no clear guidelines in place for supporting women if the consultant specialising in supporting women with medical conditions was not available, for example on leave.
- A midwife supported women who wanted to breastfeed their baby. They told us that breast feeding initiation rates were good at 68%. Midwifery staff rotated through the service and as a result the level of understanding about initiating breast feeding was high. The trust had received the United Nations Children's Fund (UNICEF) level 2 accreditation for the baby friendly initiative. This meant there was good support available for mothers who wanted to breast feed their babies.
- Specialist midwifery care for vulnerable women was very limited. There was a risk that vulnerable women would not receive specialist care when required. There was no out of hour's access to midwives who specialised in providing care to vulnerable women.
- 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. A midwife who was part of the safeguarding team supported women at risk of domestic violence.
- A concern was raised with us about lack of consultant cover over a weekend period. The workload had increased and the unit had had to close as part of the escalation policy. Some staff on the unit had been unclear about the arrangements for medical cover and had made the decision to close without consulting

medical staff as required by the escalation policy. This meant women were at risk of being transferred to another unit as a result of inadequate communication and decision making.

Learning from complaints and concerns

 The minutes of the maternity service line quality and business board (SQaBB), meetings showed complaints and concerns were discussed regularly to identify the key lessons and ensure the learning was disseminated throughout the service. Complaints, learning from incidents and patient feedback via the friends and family patient survey were all discussed by the service and quality board. We spoke to one woman who told us they would speak to senior staff if they wanted to complain. They said they were not aware of the trusts procedures but they would ask if they needed to know.

Are maternity and gynaecology services well-led?



We found the leadership in the maternity and gynaecology service required improvement and there had been little improvement in the service since our previous inspection in July 2014.

The trust had commissioned a review by the Royal College of Obstetricians to look at the leadership and management of the service. The review found no evidence to suggest an unusual risk to patient safety but highlighted the lack of clinical outcome information and the absence of outcome reviews. There was a lack of clinical ownership for clinics, inpatients and theatre lists. The report had been submitted to the trust in April 2015 but it was not clear what the trust's plan was for responding to the recommendations.

There had been a change in leadership with the head of midwifery stepping down and a new clinical director appointed. A maternity transformation project was in the early stages of development but it was not clear whether consultant medical staff were fully engaged in the work. A strategy for quality improvement across the trust had been developed and strategic objectives had been identified at specialty level however a strategy for maternity services had not been developed.

Vision and strategy for this service

- The trust had developed a strategy which focused on quality improvement across the trust. Staff felt they were aware of the Trusts strategy for achieving excellence. Communication had improved and staff were more aware of the organisations overall aim to improve service quality and safety.
- There had been considerable change in the last twelve months and staff hoped that there would now be a period of stability and an opportunity to make lasting improvements. The trust strategy included specific service strategies however during our inspection we did not see a strategy for the maternity service. When we asked about this we were told a strategy for the service had not been developed.
- A report had been produced in response to a royal college of obstetrician review setting out a departmental vision for the next five years. It was not clear whether medical staff all supported the recommendations or whether these were supported by senior managers. There were no clear timescales for addressing the recommendations made following the royal college review although several medical staff told us they were committed to responding to the issues.
- There was executive leadership for the maternity transformation project provided by the Director of Nursing. The project was still in the early stages of development and it was intended that there would be consultant obstetrician involvement in all of the work streams. The transformation programme was led by the divisional director supported by the modernisation programme office. Consultant medical staff we spoke with were aware of the work and one consultant told us they were involved in one of the work streams but was not fully aware of what was involved. We found the aims of the transformation programme were not widely understood within maternity services. We requested a description of the aims of the project however this was not provided to us.

Governance, risk management and quality measurement

• Governance arrangements had been strengthened. Incidents were reviewed weekly to improve safety, reduce risk and ensure lessons were learned and disseminated throughout the trust. There were risk and governance folders on the wards. This meant staff could

access the latest information about clinical incidents. We saw examples of the annual incident reports which were produced for every ward and clinical area. However, not all parts of the governance structures worked effectively.

- Multi-disciplinary perinatal morbidity and mortality meetings had been re-instated after an absence of several months. Monthly meetings were planned for the remainder of 2015. Midwives and consultants told us these were an important opportunity for discussing the care received by mothers and babies.
- We spoke with one consultant who told us it was difficult to capture outcome information without an information system which captured clinical information. Patient records were all maintained manually but the consultant told us they were working with trust managers to purchase a computer system which would enable them to analyse clinical outcomes. This would enable them to compare their staffing levels and outcomes with other similar services in the region.
- The royal college review which reported in April 2015 recommended the current system for reviewing cases needed re-shaping. Cases were reviewed twice a week at central delivery suite handover meetings. However, there was a large backlog of cases awaiting review, many of which were several months old. As a consequence some of the junior medical staff had not been in post when the patient had been seen and felt the reviews were of limited value.
- Dates for monthly maternity quality and governance meetings had also been planned and circulated throughout 2015. There was a risk and governance midwife, whose role was to maintain the risk register, ensure incidents were investigated and identify any corrective actions required. An on line incident reporting system had been introduced.
- Incidents were investigated and the outcomes were discussed at monthly quality and governance meetings and fed back in the midwifery newsletter. A quarterly analysis for incidents and risks was discussed by the group. For example staffing levels had been discussed as one of the top three incidents reported. We saw evidence of an incident concerning poor care planning, with no written record of delivery despite the woman having a review in the antenatal clinic with a locum doctor. Following identification of the issue a written plan had been developed which was included in the

woman's care plan. The consultant medical staff had been made aware of the incident and the importance of accurate recording of clinic discussion in the patients care plans.

Leadership of service

- The majority of staff felt well supported and felt senior staff would listen and respond when they raised issues and concerns
- An internal inquiry had been undertaken to review clinical leadership and there were plans in place to improve working relationships and support. However, we found that the internal review had not resolved the issues. The Trust's Medical Director had therefore commissioned an external review from the Royal College of Obstetrics and Gynaecology which had taken place in December 2014. The report was submitted to the Trust in April 2015. The review found no evidence to suggest an unusual risk to patient safety but highlighted the lack of clinical outcome information and the absence of outcome reviews.
- The external review found there was a lack of clinical ownership for clinics, inpatients and theatre lists. Consultant medical staff had lead roles within the specialty but it was not clear how formal these were or what the reporting relationship was with the clinical director or consultant colleagues. The roles had not been clearly defined and were not incorporated into job plans.
- The Trust were in the process of appointing to the clinical directors role. The role had been undertaken by the head of midwifery who was stepping down. The head of midwifery was also an associate chief nurse whose nursing responsibilities extended across three clinical groups as well as being clinical director. This meant the clinical director was stretched across the management of several areas and not always available to discuss issues and concerns within the service. A new divisional director had been in post for six months and medical staff informed us that the new director was available to attend the monthly business unit meetings. The new clinical director was a paediatrician.

Culture within the service

• At our previous inspection in 2014 there was a perception that medical staff did not work as part of the team and were disengaged. During our inspection in 2015 medical staff said that in the past the trust board

and managers had not listened to their concerns about senior medical staff changes which included the retirement of a consultant and long term absence of another. However changes to senior management over the last 12 months meant they felt more optimistic about contributing to the management of the service in the future and felt senior managers were listening to them.

- Midwives informed us there had been an "us and them" relationship with medical staff but things were improving. They said joint meetings were increasingly taking place and that teamwork was getting better however we noted the action plan in response to the royal college review was not being developed in a multidisciplinary way with no involvement of midwives.
- Junior medical staff said that consultants were not always personally present on the unit but that they could be contacted when required.
- A maternity modernisation board had been set up in February 2015 to oversee a programme of service improvement including new ways of working, review of rotas for consultants and midwives, a computerised record system and establishing a midwifery led unit. This board consisted of the director of nursing, mangers, consultants and midwives. We did not see a description of the strategic objectives for the transformation work. This meant it was not clear whether the programme was a collection of outstanding issues which needed to be resolved or a programme for transforming and modernising the service.

• Medical staff were concerned about the level of consultant cover. There had previously been eight consultants in post but one consultant had retired in 2014 and not been replaced. A locum consultant was in post but there were no clear long term plans in place for junior or senior medical staffing.

Public and staff engagement

- Feedback from the national maternity friends and family test in May 2015 showed 98% of respondents would recommend the ante-natal service. 100% recommended giving birth at the hospital, 94% recommended the post natal service provide on the wards and 98% recommended the community based post-natal service.
- The results were presented to the trust board monthly as part of the patient experience reports.
- Friends and family results were shared with senior medical staff via a shared drive on the trust intranet. The notes of the maternity and children's quality and business board showed the results were discussed at the board's monthly meeting

Innovation, improvement and sustainability

• A maternity modernisation board with the local clinical commissioning group and the local Maternity Services Liaison Group had identified service users to contribute to the board. This board will promote a modern service for the women of Kings Lynn and surrounding areas.

Safe

Overall

Information about the service

The Queen Elizabeth Hospital provides services for children from birth to the age of sixteen. Rudham ward has 18 inpatient beds. The number of beds had been reduced from 23 to 18 to provide a safe service following a review of staffing. The ward could increase the number of beds if the ward became busy and suitable staff were available. The ward was divided into four areas. A ten bed adolescent area known as the 'Den' which was separated into male and female areas. The main ward area had five beds providing care for children from 6 months to 11 years. There were eight cubicles for accommodating either babies less than six months or children who required isolation. Two cubicles were equipped to a higher level to provide high dependency care. Links were in place with the paediatric intensive care unit in Cambridge. A retrieval team was in place for collecting patients who needed to be transferred.

The Queen Elizabeth paediatric service also worked closely with Cambridge University to provide care for children with cancer. The Trust was a level 1 paediatric oncology shared care unit (POSCU) with the principal treatment centre in Cambridge. End of life care was provided in partnership with a local children's hospice in Quidenham.

A four bed acute paediatric assessment unit (PAU) was also located on the ward. The assessment unit enabled GPs to speak with a consultant paediatrician or junior doctor to obtain advice and discuss whether the child should be referred for assessment on the unit. The hospital also had a dedicated children's out-patient clinic.

The neonatal intensive care unit (NICU) had 10 cots for babies requiring intensive care, high dependency. The unit was designated as a level 2 unit which meant care could be provided for babies born as early as 28 weeks gestation.

A new children's emergency department opened in April 2015 which met the needs of all children including those with complex needs. The paediatric emergency department was responsible for seeing and treating approximately 6,000 children a year. The service did not have a dedicated entrance to the children's department and children were still required to pass through the main adult reception to enter the children's area.

Good

Good

As part of this inspection we spoke with one consultant six nurses and three parents.

Summary of findings

We last inspected this service in July 2014 when we found the service required improvement to ensure patients were protected from avoidable harm. Equipment was not always checked, serviced and clean. 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 the neonatal and paediatric unit. At this inspection we found the safety of the service had improved since our last inspection but nurse staffing levels remained an issue. In order to mitigate the risks the trust had taken a number of actions. The number of beds had been reduced from 23 to 18 on Rudham children's ward to ensure an adequate staff for the number of beds. Staff had been recruited to new posts and were awaiting commencement.

There was only one member of staff available to care for children attending the PAU. A business case had been developed to fund additional staff and opening hours but at the time of our inspection this had not been presented to the board and therefore approval and funding were not approved.

At our previous inspection we found an insufficient number of staff were receiving mandatory training. At this inspection training records showed that mandatory training rates were 86% compared to the trust target of 85%. Staff told us they were usually released to undertaken mandatory training. The trust had arranged additional training sessions to increase the number of staff completing mandatory training. Are services for children and young people safe?

Good

Incidents

- There were effective incident reporting processes in place. We saw examples of reports which had captured information about incidents and near misses. We saw from the minutes of meetings these were discussed as part of the trusts governance arrangements. Staff we spoke with were aware of the processes in place for reporting incidents using the electronic system used to capture information about incidents and by speaking with their manager as soon as possible. Two members of staff said there was an open culture of reporting and staff were positively encouraged to report incidents. They said learning from incidents was disseminated widely. We saw the clinical governance folders held on the ward contained information about incidents which had occurred and the actions the service had taken to prevent the risk of recurrence. The safety folder was prominently located close to the nurse's station to encourage staff to read the latest updates and reports.
- There were 89 incidents recorded for the neonatal unit for the period September 2014 to April 2015. 14 were medicines errors, eight related to admissions or discharges to the unit and six were about record keeping. Lessons learned from incidents were analysed in the neonatal unit annual incident report in March 2015. A similar report had been produced for Rudham children's ward which showed there had been a total of 110 incidents reported between September 2014 and March 2015. The majority related to appointments, admission arrangements, transfer, or discharge. Nine incidents related to medicines. The key learning points from incidents were described in the report.
- The lead nurse told us learning from incidents was discussed at the monthly ward meetings and we saw evidence these were discussed at the service's quality and business board meetings (SQaBB) and by the trusts clinical governance meetings. We saw incidents were discussed and reviewed. For example lack of staffing had been discussed at a meeting as being the most frequently reported incident.

- Complex cases were reviewed at perinatal mortality and morbidity meetings. We saw these were planned monthly for the remainder of the year. Consultant medical staff told us there had been a gap in these meetings for the majority of the past 12 months but they had been reinstated. They said senior medical staff attendance at the meetings had improved. These were used to review clinical practice and identify ways of improving the care for babies and children.
- We saw a copy of the neonatal unit annual incident report and saw a serious untoward incident had occurred. A root cause analysis had been undertaken by the trust and the learning had been shared within the trust and with other hospitals in the neonatal network. The incident involved an extremely rare condition which the medical staff had not had training for. Regional network guidelines had been developed to assist staff treat a range of conditions but these did not cover this particular one because of its rarity. Changes to medical staff training and guidelines have been implemented as a result of the incident. The case had been reviewed by senior medical staff at one of their monthly morbidity and mortality meetings.
- Paediatric staff were able to obtain advice and support from the trusts clinical governance midwife who worked on behalf of the paediatric and maternity wards. This meant the service had access to advice about incidents. Incidents were analysed to identify trends and identify any education and training which might be required.

Cleanliness Infection Control and Hygiene

- The environment within the neonatal intensive care unit and Rudham ward was visibly clean and tidy. At out last inspection we found the neonatal intensive care area was cluttered. At this inspection we found the corridors and nurseries were clear and there was no equipment or supplies being unsuitably stored in patient areas.
- Information about the effectiveness of infection prevention and control procedures was displayed in ward areas. Results of the annual infection control audit showed a high level of compliance with the procedures and low rates of infection.
- We observed that staff used appropriate personal protective equipment (PPE) such as gloves and aprons in the neonatal unit and on Rudham ward and staff used hang gel when entering and leaving the ward areas to reduce the risk of infection.

• An infection control audit had been undertaken in March 2015 by the clinical director for women and children's services. The audit reviewed a range of infection control procedures which showed there were no areas of concern for paediatrics. We saw these and both units had achieved a score of 99% since the beginning of 2015.

Environment and equipment

- At our last inspection we found equipment on the resuscitation trolley in the neonatal intensive care unit (NICU) had not been checked for several days each month during April, May and June 2014. At this inspection we found records showed the equipment had been checked on a daily basis.
- The environment on Rudham ward was appropriate for children and young people.

Medicines

- We saw medicines were stored in an area adjacent to the nurse's station on Rudham ward. We checked a sample of the medicines administration charts on the neonatal intensive care unit and Rudham ward and found these had been complete correctly. Medicines were stored in locked cupboards and fridges. A thermometer which was electronically connected to the pharmacy department measured the room's ambient temperature and showed medicines were being stored at the correct temperature. The pharmacy department were remotely monitoring variations in temperature which could affect the safe storage of medicines. We checked samples of the medicines stored and found these were all in date.
- The emergency drugs box on the resuscitation had been checked and was due for review in October 2015.
- Staff informed us that they had competencies for administering medicines which had to be completed. They told us they were required to complete a workbook designed to test their competence when they were first appointed.
- A nurse told us they had reported a medicines error on the incident reporting system and had informed the ward manager. They said they had been guided by the ward manager about what needed to be done. They had apologised to the family and informed them they could speak to the patient's advice and liaison service (PALs) to make a complaint. They had also spoken with the consultant to ask advice and make them aware of the

error. They had then completed a report reflecting on their practice. They had discussed this with the ward manager and changed their practice as a result. They told us this had been a really important learning experience and felt confident they had reduced the risk of a similar incident occurring in future. We saw the learning from the incident had been discussed at the maternity and children's quality and business board to ensure wider learning from the incident.

• At our previous inspection we found patient group directions in paediatrics required updating. These are medicines nurses can prescribe for children according to an approved protocol. At this inspection we found these had been updated but had not yet been introduced. The documents were awaiting review by the drug and therapeutic committee to ensure the protocols adequately protected children's safety before they could be introduced.

Records

- We looked at four sets of records and found care plans had all been completed and were up to date. The record of the care provided matched the care described in the child's care plan. A number of child appropriate assessments had been completed for example a nutritional assessment which had been designed by Yorkhill children's hospital in Glasgow.
- We spoke with one child's relative who told us, "They have been absolutely fantastic." They said they had their baby at the hospital and had not known much about the service at the time. They said they had not known what to expect. They told us, "I have had great advice I was so worried but staff have been really helpful and understanding." They told us the ward had kept in contact and telephoned them to keep them informed.

Consent

• We spoke with a parent who told us they were not able to stay with one child because they were at home looking after their other child. They said "The ward staff rang at 1am to discuss putting a feeding tube in a place. They said staff had discussed consent and the plan for looking after the child for the night. The relative said they felt fully informed and reassured. • Care plans contained consent to treatment records which had been signed by parents and carers. Children and adolescents were also able to co-sign the consent forms and we saw examples of this in the care plans we looked at.

Safeguarding

- Training records showed 90% of staff had received training in safeguarding. There was a designated trust safeguarding nurse for children that staff could contact for advice. Staff told us the safeguarding nurse had been off for several weeks but they could raise any concerns with the ward manager or other senior staff. Staff told us this had resulted in reducing the level of safeguarding supervisions they received. When we spoke with the service manager about this they said they were not sure what arrangements were in place for the safeguarding lead's absence. Staff were aware there was also a designated safeguarding doctor they could speak to.
- There were records of children's safeguarding meetings which had wide representation from departments across the hospital. Serious case reviews had been discussed where the trust had worked with local authority safeguarding teams. The committee monitored the level of safeguarding training required and the level of compliance. The minutes showed 99% of staff requiring level 1 had completed it , there was 94% compliance for staff requiring level 2 and 76% staff trained for level 3, the highest level of training required for staff who managed services for children.
- We spoke with three staff who told us they received regular training updates on safeguarding and they were all aware of the importance of reporting any concerns to the ward manager or safeguarding lead. One member of staff told us they were aware who to contact outside the hospital should the need arise.
- Staff on the neonatal intensive care unit told us they had recently completed a baby snatch drill to test the units procedures for making sure babies were safe and not vulnerable to being abducted from the ward. Staff told us it had been very useful and they had changed their procedures as a result.

Mandatory training

• Training records showed that mandatory training rates were 86% compared to the trust target of 85%. Staff told us they were usually released to undertaken mandatory training but this depended on there being enough staff cover available to release them to attend.

Management of deteriorating patients

- There was a paediatric escalation policy for children whose condition deteriorated. Arrangements were in place for children to be transferred by the specialist children's acute transport service (CATs) which operated throughout the East of England. This meant a child who needed to be transferred was cared for by a team who specialised in supporting a child who needed to be transferred to another hospital.
- A plan had been developed for NICU which provided guidance for staff to ensure babies received safe care on the unit. The policy was designed to be used when there was high activity, a shortage of cots or when staffing shortages raised concerns about the quality and safety of care. Staffing levels were monitored throughout the 24 hour period at staff handovers. The unit followed the British Association of Perinatal Medicine standards for the number and skill mix of staff. The policy required prioritising the needs of babies on the unit. A number of actions had been identified ranging from staff re-deployment from other areas to closing the unit to new admissions and arranging for babies to transfer to other units. The unit was part of a regional network which had developed a pathway for transferring babies based on the length of the pregnancy and the complexity of the baby's needs.
- The paediatric department used an early warning system for monitoring a child's condition and identifying when their condition deteriorated. We saw examples of the paediatric early warning system (PEWs) being used in care plans.
- Rudham ward had two high dependency beds in place on the ward. These were used to care for children who required higher levels of care because of their condition. Staff were aware of the escalation processes in place if a child's condition deteriorated.

Nurse staffing

• At our previous inspection we found the NICU was not staffed in line with the British Association of Perinatal Medicine (BAPM) standards for staffing. The paediatric unit was also understaffed by 2.5 whole time equivalent nurses. The trust had identified staffing as a significant concern on the trust's risk register. The unit kept figures on the number of occasions staffing levels fell below recommended levels. These showed this had occurred on 18 occasions between January and March 2015 and 49 times between September and December 2014. 29 babies were transferred out of the unit in the 12 months prior to March 2015 as a result of inadequate staffing levels. The unit worked closely with other trust in the regional network to agree transfers out of the unit or to receive transfers in including babies transferring back to the Queen Elizabeth hospital. The unit had not closed in the three months January – March 2015 but had closed 14 times in the period September to December 2014.

- At this inspection we found the trust had invested in additional nursing staff but not all new staff were in post. The paediatric unit had also reduced the number of beds in use from 23 to 18. These could be increased if sufficient appropriately trained staff were available. Staffing did not meet the levels required as stated by British Association of Perinatal Medicine (BAPM) or the neonatal intensive care unit or the Royal College of Nurses paediatric nurse staffing levels. A protocol had been developed for managing the risks of unsafe staffing on the neonatal unit which contained measures such as re-deploying suitably trained staff and also closing the unit to admissions when necessary.
- The neonatal unit annual incident report showed the highest number of reported incidents in neonatal intensive care related to staffing issues with 46 incidents recorded in 2014. A neonatal network peer review had taken place in October 2014 which had highlighted the unit required 31 staff to meet the required staffing levels. At the time of the review there were 22 staff in post a shortfall of nine staff. Since the review the trust had funded an additional 2.75 posts. At the time of our inspection the trust were in the process of appointing to these posts. Permanent staff worked additional hours to cover staffing shortfalls together with bank nurses when available, Staff were transferred from Rudham children's ward if available although this was not always possible as Rudham children's ward was also understaffed.
- The risk register showed the trust had made the decision to hold bed numbers at 18. A skill mix review had identified there was sufficient staffing for 18 beds. The number of beds would be increased according to need for example in the winter if there were sufficient qualified staff available. The risk had been reviewed in

June 2015 and was due to be reviewed again in six months. At the time of our inspection there were three whole time equivalent vacancies. The service manager told us the posts had been recruited to but new staff were not yet in post. They expected newly appointed staff would take up their posts over the summer.

Staffing levels on the paediatric assessment unit (PAU) did not achieve the Royal College of Nursing paediatric staffing levels of one member of staff to four. A business case had been developed to fund additional staff and opening hours but at the time of our inspection this had not been through board approval and it was not definite that this would be funded.

Medical staffing

- The staffing skill mix shows the proportion of Consultant grades was 27% compared to 34% nationally and were lower than the England average and junior level grades were 12% compared to 7% nationally which were higher than the England average.
- Medical staff told us the paediatric medical team worked effectively to ensure doctors in training had access to education and supervision. Junior medical staff told us there were regular teaching sessions held several times a week.

Responsive

Well-led

Overall

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 specialist palliative care team provided support to staff and patients across the trust. Specialist palliative care was provided as part of an integrated service across acute and community settings. Medical input to the specialist palliative care team included two consultant posts (vacant at the time of our inspection) and a middle grade doctor. There were six band seven specialist palliative care nursing posts, including a newly appointed end of life care facilitator who was due to start in the coming weeks. There were four band six specialist palliative care nurses, three of whom were in post, including one discharge liaison nurse with the 4th post being recruited to at the time of our inspection. Two newly identified part time posts, for an occupational therapist and a palliative care social worker, were also being recruited to. A palliative care co-ordinator managed referrals and coordination of activity and provided administrative support. We saw that referrals to the integrated service totalled 1346 between April 2014 and March 2015.

During our inspection we spoke with 26 staff including a middle grade palliative care doctor, the lead end of life care nurse, the cancer services group clinical director, the medical director, an elderly care consultant, specialist palliative care nurses, mortuary staff, chaplaincy staff, porters, medical staff, ward managers, nursing staff and allied healthcare professionals. We visited a number of wards and clinical areas across the hospital including general medicine, surgery, respiratory, care of the elderly, the stroke unit, oncology and haematology and the accident and emergency department. We also visited the mortuary and we observed a multi-disciplinary specialist palliative care team meeting. **Requires improvement**

Requires improvement

Requires improvement

Summary of findings

During our previous inspection in July 2014 end of life care services were safe, effective and caring but improvements were required for them to be responsive and well led. During our current inspection we saw that improvements had been made but further improvements were required for the trust to be responsive and well-led in end of life care.

There had been no palliative care consultant in post since March 2015. While they had arrangements in place to support the service with input from a middle grade palliative care doctor and telephone input from consultants from another provider, there was no specialist clinical lead for the service or the newly ratified end of life care strategy.

Improvements had been made since our last inspection in 2014. For example, there was a board level lead for end of life care, an end of life strategy had been developed, a review of the specialist palliative care team had been completed with additional investment in new posts, the 'Five priorities of care' for patients at the end of life were due to be implemented over the coming months, additional end of life care mandatory training had been developed and the mortuary was being refurbished to ensure improved care after death.

Specific areas where improvements were still required included the development of a plan for specialist consultant input in the event of continued recruitment difficulties. Complaints and significant events were not being appropriately coded for end of life care so information was not being used to improve services. Other areas where information was not being used to improve services included mortality meetings that were not focusing on the end of life care journey, the trust

was not routinely surveying patients or relatives regarding end of life care and audits to evaluate the quality of care provided were not routinely being carried out.

Are end of life care services responsive?

Requires improvement

End of life services were not responsive to the needs of patients. Patients were admitted to the hospital under the care of a consultant other than a specialist palliative care consultant as both palliative care consultant posts were vacant and the trust had not been able to successfully recruit. The lack of consultant face to face time meant that there was a risk that the service may not be responding to the needs of patients in a robust way. This had not been incorporated in the trust's end of life care risk register. The specialist palliative care nurses provided a face to face service seven days a week and a telephone advice line out of normal working hours. Staff we spoke with told us the palliative care nurses were responsive to the needs of patients and non-specialist staff. Data recording was inconsistent which meant it was difficult to gauge an appropriate level of responsiveness in terms of non-cancer end of life care

Preferred place of death was recorded in the patients palliative care records at the point of referral by the specialist palliative care team and the trust had incorporated the question into documentation for patients at the end of life in ward areas. A discharge coordinator was in post to support the fast track discharge of patients at the end of life and we saw that continued improvement in this area was a key element to the trust's end of life care strategy. Staff told us that it was sometimes difficult to nurse patients at the end of life in a side room due to limited side room availability. However, we were told that an improvement in the trust's infection rates had meant that there was greater availability of side rooms for end of life care. Nursing staff we spoke with told us they advocated on behalf of patients for the use of side rooms for end of life care but that in some areas this was difficult, for example we were told that patients at the end of life on Oxborough ward were generally nursed in ward bays rather than side rooms. The trust had progressed plans for the refurbishment of the mortuary and we saw that work had started on this.

Service planning and delivery to meet the needs of local people

- The palliative care nursing team were available seven days a week from 9.00am to 5.00pm. Out of hours advice was available from a telephone advice line manned by the team.
- The trust had looked at local demographic data when developing their strategy, highlighting a high proportion of older residents and that only 50% of people die in their usual place of residence.
- Following our inspection in July 2014 where the need for improvement in the timely discharge of end of life patients had been highlighted the trust had appointed a discharge coordinator and a newly appointed end of life care facilitator was due to take up their post to help fast track patients through the discharge team.

Meeting people's individual needs

- Where possible side rooms were prioritised for patients at the end of life although side room availability was limited in the hospital. Staff we spoke with told us they felt that side room availability for patients at the end of life had improved somewhat due to improvements in infection control across the trust. We were told that the greatest barrier to side rooms being available for end of life care patients had been that they were often used for patients who required barrier nursing.
- Preferred place of death was recorded by the specialist palliative care nurses as part of routine information recording when a patient was referred to the team. A discharge liaison nurse post had been created as part of the Queen Elizabeth Hospital (QEH) specialist palliative care team. Annual data for 2014 showed that of 151 patients with a recorded preferred place of death, 61% (92) had been achieved.
- A care rounding tool had been introduced within ward areas for patients thought to be at the end of life and included prompts to discuss preferred place of death and other aspects of care with patients. A care rounding tool is a tool that prompts staff to carry out regular assessments of patients, in this instance the care rounding tool was designed specifically for patients at the end of life. Preferred place of death was being recorded as part of the last days of life documentation.
- A multi faith chaplaincy was available 24 hours seven days a week. The hospital had a 'sacred space' which was a multi faith area for patients, visitors and staff. We

saw that the space was well equipped for people from different faiths. We were told that the chaplaincy service supported patients and relatives of different and no specific faiths or beliefs.

- Interpreters were available via a telephone service or face to face via staff working in the hospital.
- Staff had received training in dementia awareness and we saw information available to support patients with a learning disability. Staff information boards in ward areas included information on assessing mental capacity, and focusing on the individual when caring for someone with dementia. Records showed that 91% of trust wide staff had attended dementia awareness training.
- Staff told us they had access to specialists in learning disabilities and dementia should they need additional support.
- Written information was available on ward areas and on the trust website for patients and relatives. Specific information relating to end of life care included a booklet on advance care planning and a guide to decisions about cardiopulmonary resuscitation (CPR). We viewed minutes of the end of life care steering group meeting, which was held every six weeks, and saw that a current task the steering group was working on involved the development of an information guide for patients and relatives on what to expect in the last hours/days of life.
- While space was limited on ward areas for staff to have private discussions with patients or relatives, we saw that staff made efforts to ensure discussions were held in private. We observed staff taking relatives into a quiet room on Shouldham Ward to hold a discussion.
- A bereavement room was opened in the Emergency Department in October 2014 and had been designed as a quiet and calm space. At the time of our visit the mortuary was being refurbished and we viewed progress and plans that showed a dedicated viewing room was being developed. Staff we spoke with felt the space was well designed and would help to create a peaceful atmosphere for friends and family.
- We saw that the trust had invested in new bariatric equipment to meet the needs of bariatric patients at the end of life. Equipment included bariatric mortuary fridges and a concealment cover for use in transporting the deceased.

Access and flow

- At the time of our inspection there was no specialist palliative care consultant in post. Patients requiring end of life care were admitted under the care of a consultant, for example a haematologist or oncologist. A middle grade doctor provided specialist palliative care input with support from palliative care consultants from another provider. The trust told us they had been offered face to face input from another providers palliative care consultants for complex patients but had not felt they needed to take this up to date.
- Patients requiring specialist palliative support were referred to the specialist palliative care nurses by ward and community teams and other speciality consultants.
- Multidisciplinary team (MDT) board rounds were carried out on wards and nursing staff used specific prompts and assessment tools to support patients in the last days and hours of life in terms of their care decisions. The board rounds enabled key staff to discuss and plan aspects of care and prioritise for the day ahead such as discharge to preferred place of care on a daily basis.
- There were four beds on Shouldham ward that were dedicated palliative care beds but staff told us that as there was no palliative care consultant in post patients would be looked after under the care of the haematology or oncology consultant.
- Nursing staff told us they advocated on behalf of patients to try and ensure that patients at the end of life could be nursed in a side room where possible.
- The specialist palliative care nurses and middle grade doctor would see patients in all wards and departments within the hospital as appropriate to ensure their needs were being met.
- Between April 2014 and March 2015 the specialist palliative care team received 1346 referrals. Of these, 86% were seen/contacted within 24/48 hours, 13% were unknown because the information had not been recorded and 1% were seen/contacted after 48 hours.
- 64% of referrals were unspecified in terms of their cancer/non-cancer status. Of those recorded 98% of referrals were for patients with a cancer diagnosis. Because of the unrecorded data it was difficult to gauge an appropriate level of responsiveness in terms of non-cancer end of life care. Staff told us their focus was on end of life care irrespective of the diagnosis.

Learning from complaints and concerns

• We spoke with one patient who was happy with their care and knew how to complain if required.

• Specialist palliative care staff were able to tell us about some complaints relating to the care of patients at the end of life and told us that when complaints were received these were discussed in team meetings with a view to learning. However, complaints weren't specifically recorded under an end of life care category so there was no process to identify and review complaints relating to end of life care as a matter of routine. The trust was aware of this and we saw an action point in relation to this as part of the end of life steering group work plan.

Are end of life care services well-led?

Requires improvement

The trust had developed a clear vision and strategy that had been approved by the trust board in January 2015. We saw that staff had worked hard and some progress had been made in the implementation of the strategy; however the trust did not have a palliative care consultant in post which impacted on the clinical leadership of the strategy and the service. Information was not always being used to improve care. For example, we saw details of process audits such as do not attempt cardiopulmonary resuscitation (DNACPR) decisions but did not see examples of how audits were then being used to evaluate and improve care. Complaints and significant events were not evaluated in relation to end of life care although we saw that the trust had identified this as a gap and planned action to address it. Monthly mortality meetings were carried out but these were not focused on the end of life care journey or improving end of life care. The trust was not routinely surveying patients or relatives regarding end of life care and there was no evidence of understanding of local results of the national bereavement survey. However, we saw that the trust had begun to explore this area and had held a bereaved relatives focus group in May 2015 to begin to identify areas of improvement.

The trust was working to progress the implementation of the five priorities of care for end of life and staff were aware of this. There was executive input into end of life care and staff told us they felt that end of life care was being prioritised within the trust. The trust had invested in end of life care with a review of the specialist palliative care team and subsequent development of new posts, such as an end

of life care facilitator. We saw that the trust planned to task new post holders with lead responsibilities in taking forward the end of life care strategy. There was evidence of service development with the implementation of a ward companion initiative.

Vision and strategy for this service

- The medical director had taken the lead for the development of end of life care within the trust and a non-executive director had also been appointed since our previous inspection in July 2014. This was an action arising from the 2013/14 National Care of the Dying Audit (NCDAH).
- A review of the specialist palliative care service had been completed since our last inspection. As a result of this, additional posts had been developed. This included two band 6 specialist nursing posts. The trust had also appointed a new end of life care facilitator role and a fast track discharge liaison post. Macmillan funding had been sourced to develop dedicated occupational therapy and social work posts within the service and these posts were being recruited to.
- An end of life care strategy had been ratified by the board in January 2015. The medical director had developed an end of life care steering group with a task and finish remit to lead the implementation of the strategy. Oversight of this group was undertaken by the quality committee which the group reported into.
- The vision for the strategy was to ensure patients at the end of life were treated as individuals with dignity and respect and had the best possible end of life experience in appropriate surroundings which met their wishes wherever it is possible to do so.
- Staff we spoke with told us they felt there was a renewed commitment to good quality end of life care at the top of the organisation. We saw that one of the aims of the trust was to make end of life care everyone's business.
- All staff we spoke with were aware of the work of the end of life steering group. Members of the steering group spent time in ward areas discussing end of life care with staff and information was available on notice boards.

Governance, risk management and quality measurement

• The specialist palliative care team report to the Cancer Services Group. There was a palliative care lead nurse in post who was identified as the end of life lead.

- At the time of our inspection there was no palliative care consultant in post, with the trust having been unsuccessful in the recruitment to two vacant consultant posts. This meant that there was no consultant level specialist palliative care input into end of life care within the trust and there was a risk that the service may not be responding to the needs of patients in a robust way.
- An end of life care risk register identified specific risks for end of life care services. There were two risks identified. one that patients at the end of life may not have a personalised care plan in place following the withdrawal of the Liverpool Care Pathway (LCP) and the delayed implementation of the five priorities of care. The five priorities of care are; recognition of the possibility that someone might die, that sensitive communication takes place, that the individual and those important to them are involved in decisions, that the needs of those important to the dying person are met and that an individual comprehensive plan of care is developed (Leadership Alliance for the Care of Dying People). The second risk was that patients may not die in their preferred place of death due to a discharge liaison post only being in place 5 days a week. We did not see a risk identified relating to the absence of a palliative care consultant in post.
- Risks identified were rated red, amber and green depending on considered level of seriousness and risk. Risks included details of cause and effect and had identified control measures in place.
- The end of life care steering group had developed an action plan and we saw that the priority for action had been to develop multidisciplinary engagement around end of life care. A the time of our inspection the focus had been on implementing and embedding the 'Five Priorities of Care' in order to achieve the best possible experience for patients and their relatives.
- There was limited monitoring of quality improvements within the trust at the time of our inspection. Audits of DNACPR were undertaken however there was no evidence that audits were then being used to evaluate and improve care.
- The trust were not coding any incidents, complaints or significant events for end of life care which meant that these were not being monitored or reported on. This meant that there was no oversight of quality indicators for end of life care.

- The trust had identified that complaints needed to be filtered through the electronic systems so as to identify when a complaint related to end of life care. This was included in the end of life steering group action plan, and identified for completion in April 2015 but was yet to be completed.
- We viewed minutes from the end of life care steering group and saw that these were attended by representatives from a number of areas. These included the specialist palliative care team, acute medicine, surgery, neurology, senior and junior nursing, occupational therapy, chaplaincy and Macmillan patient support and information services.
 - The trust was due to participate in the National Care of the Dying (NCDAH) audit later in the year. Therefore, current data was not available at the time of our inspection, however a previous audit in 2013/14 showed that the trust did not achieve 4 of the 7 organisational key performance indicators and performed worse than the England average for seven out of ten clinical indicators. Actions taken to improve performance in the NCDAH included the development of trust board representation and planning for care of the dying and a focus on the implementation of the five priorities of care to address areas such as multi-disciplinary recognition that the patient is dying and improving communication regarding the patient's plan of care.
- Areas that had yet to be fully addressed included providing access to information relating to death and dying and providing formal feedback processes regarding bereaved relatives and friends views of care delivery. However, we saw that the development of information was being addressed as part of the end of life care steering group's action plan and that a recent bereaved relative's feedback event was held to identify themes for improvement.
- There were limited data reports available to demonstrate the effectiveness and quality of the service and information was not being used to improve care. Staff we spoke with told us data was available in the system but that in the absence of a palliative care consultant the information was not being used to develop routine reports.
- Mortality and morbidity meetings and reviews did not have specialist palliative care consultant input at the time of our inspection due to the consultant posts being vacant. The middle grade doctor told us they undertook

reviews of patients who died on Shouldham ward; these would then be passed to the medical director. Mortality reviews were focused on the cause of death and not the process of death or the care at the end of life.

Leadership of service

- We saw evidence of good local leadership at ward level, with end of life care being seen by ward managers and staff as a priority in terms of quality and meeting patient needs and wishes.
- There was a commitment at board level to the provision of good quality end of life care. This was demonstrated in the development of an end of life care steering group to deliver the strategy and in the investment of new posts to develop end of life care services.
- There were two vacant palliative care consultant posts at the time of our inspection. A locum consultant had been in post until March 2015 and the trust had been unable to recruit to either a substantive or locum post since then.
- At the time of our inspection there was a staff grade doctor in post with telephone support provided to them from specialist palliative care consultants at another provider. We were told that these consultants had offered to run clinics at the trust to enable face to face consultant provision but that the trust had not felt this was needed. The absence of consultant input on a day to day basis meant there was a lack of clinical leadership.
- Staff we spoke with on the wards and in clinical areas told us the specialist palliative care nurses were supportive and quick to provide guidance in terms of good quality end of life care.
- We saw that the trust had invested in improved end of life care teaching for staff. This included the development of mandatory training for foundation level doctors and two hour mandatory training for nursing staff around end of life care. This training was in its infancy and data figures were unavailable.

Culture within the service

- Staff told us they felt they had the opportunity to provide good standards of end of life care and that this was easier with the commitment and leadership from the top of the organisation.
- We observed good team working and saw that staff were focused on working together in order to make a

difference to patients. Patients we spoke with told us they believed the staff to be committed to good quality care and sensitive to the needs of patients and relatives at the end of life.

• Staff were proud of the service they were able to deliver and were focused on the needs of individual's at the end of life.

Public engagement

- The trust had not looked in detail at the national survey of bereaved relatives and had not undertaken their own survey as to the experience of relatives of patients being cared for at the end of life within the trust.
- Engaging with bereaved relatives was an area the trust planned to develop and had held a feedback event in May 2015 to gather the views of relatives as to the quality of end of life care within the trust. We saw that themes identified for improvement as part of this exercise were communication between staff and patients and relatives and the environment in which patients were being cared for at the end of life. The trust was in the process of using this information to develop further feedback mechanisms with relatives and patients with the aim of improving services.

Staff engagement

- Clinical staff at different levels of the organisation were invited to participate in the end of life care steering group, for example both senior and junior nurses were represented on the group.
- The trust had plans to refresh an end of life care link nurse programme to develop champions in end of life care across the trust. This was due to commence once the end of life care facilitator was in post from September 2015.

Innovation, improvement and sustainability

• The specialist palliative care team were members of the East of England Strategic Clinical Network for end of life care.

- There was evidence that the trust was working closely with local Clinical Commissioning Groups (CCG) to develop end of life care services across the region. The medical director regularly attended regional CCG meetings and the CCG had been involved in discussions about areas such as consultant recruitment issues.
- The trust worked with other service providers such as hospices in the locality to provide joint services and participated in local network meetings.
- Specialist palliative care staff told us they felt there had been improvements in service development and they felt positive that this would continue into the future with the recruitment of new staff to newly developed posts.
- The trust has been focused on the implementation of the five priorities of care as a guide to good quality end of life care. We saw that cards had been developed for staff in clinical areas to use as prompts. We also saw that a tree symbol had been developed into a magnet to attach to boards in clinical areas against the patient's name and used to identify patients who were at the end of life in a discreet and respectful manner.
- The specialist palliative care team had identified work streams around service development which were then allocated to team member to be a lead role in each specific area. This included representation on the end of life steering group, education, policy development, audit and reforming the hospital multidisciplinary team.
- The trust board had committed to investing in end of life care services with the development of new posts and the adoption of the end of life care strategy.
- The trust had participated in a pilot of ward companions in partnership with the information centre coordinator, specialist palliative care and ward teams. Ward companions are volunteers who spend time sitting with patients who are at the end of life. Feedback about the pilot had been positive from both family members and nursing staff. The end of life care leads told us the trust had committed to training a pool of volunteers over a period of two years for this role which will be audited and the results documented after year one.

Safe

Responsive

Overall

Requires improvement

Requires improvement

Requires improvement

Information about the service

The outpatients department at the Queen Elizabeth Hospital is divided into several distinct areas. The department covers a variety of different specialties which include general surgery, dermatology, ophthalmology, orthodontics, neurology and orthopaedics.

During this inspection we visited the main outpatient and orthopaedics department. The inspection team spoke with eight patients, three relatives and 14 members of staff which included; nursing staff (registered and non-registered), managers, and reception staff. We observed patient care and their treatment, inspected equipment and reviewed performance information provided by the hospital.

Summary of findings

During our last inspection in 2014 we found that the outpatient department (OPD) required improvement in safety and responsiveness as there were issues around cleanliness in the department which presented infection control risks and concerns around the safe storage of medicines as we found prescription only medicines unsecured. There were concerns that the service did not respond to the needs of all people as, for example, the signage for ophthalmology was poor.

At this inspection we found that the outpatients department had made some improvements however still requires improvement in order to be safe and responsive. There were concerns around the safe storage of medicines and the safe keeping of patient records. Access to services was inconsistent with significant delays in some specialties. Patients were affected by short notice cancellations of appointments and not all patients were able to get an appointment in a timely manner. The department was visibly clean and the staff were proud of the improvements that had been made in the department, such as the changes to the fabric of the department, the new chairs provided and the introduction of whiteboards to keep patients updated with information regarding their clinics. Staff felt well supported in their role and they were encouraged to develop their skills and knowledge base.

Staff demonstrated a commitment to patient–centred care. Patients were treated with dignity and respect and patients spoke highly of the staff. There were good links with other community services. The department was providing extra clinics in some specialties, including cardio respiratory and audiology, to improve patient access and reduce delays and additional "Hot Spot" clinics were provided so that patients requiring urgent referrals were seen quickly. Infection prevention and

control had greatly improved since our last visit with a clear audit process in place to ensure that care and treatment was delivered in line with current national standards and legislation.

Are outpatient and diagnostic imaging services safe?

Requires improvement

Safety within the outpatients required improvement. Outpatient services did not consistently work in a way that protected patients from harm, for example prescription only medicines and patient records were not always stored in a safe manner. We saw that medicines storage had improved with the fitting of a new medicines cupboard with a light that alerted staff when the cupboard was open. However, there were prescription only medicines left in an unlocked cupboard in an unattended and unlocked consultation room at the time of our inspection. This meant that medicines were not being stored safely in line with national guidelines.

Medical records were not securely stored in all areas. We observed patient records stored in a publicly accessible area in the orthopaedic clinic. This meant that records containing confidential personal information were not stored securely and there was a risk that data protection could not be assured.

Staff were aware how to report incidents and evidence of learning and appropriate feedback to staff in relation to this learning was apparent. Staff were aware of the procedures relating to safeguarding and had undergone relevant mandatory training

There had been significant work carried out to improve the fabric of the department since our last inspection. Some areas, such as the main out-patients area, had been redecorated, new signage was in place in some areas, including ophthalmology, and additional seating had been placed in the waiting area. The department appeared visibly clean and infection control procedures were in place with cleaning schedules and regular audit checks implemented.

Incidents

- One serious incident relating to a pressure ulcer had been reported between March 2014 and February 2015.
- Incidents were reported using an electronic reporting system. Staff were aware of reporting processes and their role within this.

- When an incident was reported, an analysis of the incident was undertaken. We reviewed summaries of outpatients incidents and saw that each incident included a summary description of the incident, the action taken immediately and action taken as a result of the investigation.
- Quarterly and annual incident reports were issued to the department in order to facilitate wider organisational learning from incidents.
- We saw that incidents were reviewed with a view to the identification of trends and that when trends were identified there were processes in place to report on these and address them with the involvement of relevant staff. For example we saw that incidents relating to the use of an electronic booking system had led to prompts being incorporated into the system and a reduction in the number of incidents as a result.
- We reviewed minutes of meetings for OPD. Incidents were discussed with staff and formed part of regular discussions at staff meetings and were included in the minutes.
- Managers we spoke with had a good understanding of their responsibilities around duty of candour and informing patients when incidents occur. The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred.

Cleanliness, infection control and hygiene

- There were adequate hand washing facilities, liquid hand gel and personal protective equipment (PPE) available. Staff adhered to trust policies and guidance on the use of personal protective equipment (PPE), and to 'bare below the elbow' guidance, so as to help prevent the spread of infection.
- Regular hand hygiene audits by the infection control team had taken place and results were cascaded within the department. A hand hygiene audit undertaken in May 2015 showed 100% compliance in the main outpatients department.
- Weekly cleaning audits were carried out by the domestic supervisors. In addition the infection control team carried out annual environmental audits of areas such as waste disposal, disinfection and the cleanliness of equipment. The 2014 main outpatient's environmental audit showed 100% compliance.

- We observed clinical and patient areas to be visibly clean and tidy. Medical equipment was dust free and visibly clean.
- Curtains and privacy screens were changed every six months, were dated clearly indicating the date of change and were regularly audited by the outpatient department matron.

Environment and equipment

- Staff reported that the environment in the outpatients department had improved since the last inspection. We noted that some areas had been repainted, for example in main outpatients, and that new signage was in place.
- During our inspection all patients in the waiting areas had access to a seat and there was adequate room for manoeuvring wheelchairs.
- Equipment within the department had been checked and serviced as appropriate and was visibly clean.
 Equipment had been PAT tested within the preceding 12 months.
- Resuscitation equipment in each clinic was checked daily and found to be correct. This was documented and signed for by staff daily and the records supported this.

Medicines

- Medicines were in date and stored at the correct room temperature. Ambient temperatures were being monitored.
- A new medicine's cupboard had been installed in the main outpatients department. This included the installation of a warning light that alerted staff to the cupboard being left open. We observed the cupboard to be locked during our inspection.
- Medicines were not always stored correctly. We
 observed prescription only medicines stored in an
 unlocked cupboard in an unlocked consulting room and
 brought this to the attention of the nursing staff. Staff
 told us medicines were not normally stored in
 consulting rooms and were unable to give us an
 explanation as to why they were there.

Records

• Incidents relating to patient information such as records, documents, test results and scans accounted for 22% of reported incidents in outpatients from January to December 2014.

- Staff told us that sourcing patient notes was sometimes problematic and time consuming due to incorrect filing and missing notes.
- We did not see an incident trend report relating to patient records and there had been no serious incidents relating to records management reported.
- During our inspection of the fracture clinic we found an unsecured area off a patient corridor that contained patient records. There was also an unlocked store cupboard that contained unsecured patient records containing personal confidential information. There were in excess of 50 unsecured records.
- Risk assessments were carried out with all risks rated using a red, amber and green (RAG) system depending on level of significance and cause, effects and control measures identified.

Safeguarding

- Staff had completed training for safeguarding adults and children and staff were confident in reporting safeguarding concerns. 91% of healthcare staff in outpatients had attended training in safeguarding children and adults.
- Information was available in the department on how staff should escalate concerns with details of how to contact the safeguarding team.
- Staff gave us examples of when they had escalated concerns, for example when children did not attend (DNA) more than two clinic appointments or where there were concerns about vulnerable adults.

Mandatory training

- Staff mandatory training records mandatory training compliance for outpatients was at 92%, 7% above the trust's target of 85%.
- Mandatory training was linked to staff appraisal records for monitoring purposes. Appraisals were up to date for 88% of nursing staff.
- Mandatory training was delivered by various methods including; Elearning online and face to face and included areas such as safeguarding, resuscitation, infection control and fire training.
- Allocated time for staff to attend training was identified and evidence through minutes of meetings where senior staff had allocated staff to mandatory training sessions.

Assessing and responding to patient risk

- Staff were clear about the procedure to follow if a patient deteriorated while visiting outpatient clinics. For example, on the day of our inspection a member of staff stayed with a patient who was identified as at risk. 91% of staff working in outpatients had attended resuscitation training.
- There were adequate numbers of resuscitation trolleys available in each clinical area. Each department was responsible for carrying out daily checks of resuscitation equipment and we saw records to demonstrate this.

Nursing staffing

- The department was staffed by a mix of registered nurses and health care assistants.
- The department had undertaken a review of the nursing hours required to run the service as part of the trust's outpatient transformation programme. Managers told us that four whole time equivalent (WTE) nurses had been recruited and were due to commence in post in the coming weeks and months.
- Additional staffing was provided by 'bank' staff who had attended mandatory induction and training within the department.
- Clinic bookings were reviewed by the nursing sister two weeks in advance and additional bank staff were booked as required to ensure the appropriate skill mix of staff was available.
- A training needs assessment had identified extra training to develop staff and bridge skill gaps for nursing staff up in specific areas. One example of this was in compression bandaging within the dermatology clinic.
- The trust had worked with other trusts to develop an apprenticeship scheme and we were told they were also looking at developing advanced nurse practitioner roles and had started to offer extra training to their own staff, for example providing ECGs, phlebotomy and compression bandage training to staff to improve their skill base.

Medical staffing

- Clinics in outpatients were run by medical staff of mixed grades with the appropriate skills for the clinic, for example the orthopaedic clinic was run by orthopaedic medical staff and there was a seven day consultant led radiology service available.
- Staff told us that medical staffing was problematic across the trust and that as part of the outpatient transformation programme the trust were looking at

different ways to address this. One area identified was the development of nurse practitioner roles within outpatients, there was one regular nurse led clinic in ENT.

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.
- There were business continuity plans in place for outpatients. Plans addressed possible scenarios that could interrupt the flow of normal business and impact, control measures and actions had been identified to manage the risk.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

The outpatients services were not responsive and required improvement in a number of areas. Whilst the trust was meeting the majority of referral to treatment targets, there were an unacceptable number of patients waiting over 18 weeks for clinic appointments. At the time of our inspection there were 981 appointment slot issues (ASIs). Access to the pain clinic was a particular concern, with patients experiencing long delays for appointments and a large number of clinics were being cancelled at short notice. To improve access and flow to the outpatient service the trust was providing additional out of hours clinics in some specialties and additional "Hot spot" clinics were being held to ensure the most urgent patients were seen in a timely manner.

However the outpatient department had made a number of improvements since our last inspection in 2014. The trust had systems in place to assist and support patients for whom English was not their first language, for example letters and leaflets were produced in other languages as required. The signage in the outpatients department was good, however this was not consistent in all areas, for example signage to the pain clinic abruptly stopped en route. Staff were friendly and responsive to people's individual needs.

Service planning and delivery to meet the needs of local people

- The outpatients department was clearly signposted and upon entering the hospital a receptionist was available to direct people when required. The receptionist was friendly and proactive in addressing people's needs, for example she approached an elderly couple as they entered the hospital and assisted them in finding their way
- However some clinics were not well sign posted, for example, way-finding signs to the pain clinic stopped abruptly en route, meaning there was a risk patients could become lost or confused.
- Children's provision within the outpatient department was very limited. Children's waiting areas were bland and the toys that were provided were aimed at very young children. There was no provision for adolescents, such as age appropriate magazines. We spoke with two children, who had been waiting in the fracture clinic, who told us that it was boring. They suggested that "a television or some comics" might be appropriate for their age group.
- Following feedback from people accessing the service, there had been an increase in seating provided, with the trust purchasing an extra 20 seats for the outpatient department and a ramp had been installed at the entrance to improve accessibility.
- Some specialities made use of, an automated telephone reminder service system that asked patients to confirm their attendance or to cancel the appointment if they could no longer attend. This allowed the hospital to maximise service provision by offering cancelled appointments to other people.
- Additional clinics were provided at weekends and in the evenings in some specialties to ensure people were seen in a timely way. These included the audiology clinic, which ran extended hours, the cardio respiratory clinic, which had additional Saturday clinics, and extra ear, nose and throat (ENT) clinics which were provided to reduce the waiting time for follow up appointments
- Patients told us that the information provided to them before their appointment was clear and that they had developed good relationships with staff when repeated appointments were necessary. One patient told us that the service seemed "much more efficient".
- There was no fresh drinking water available for patients waiting in the West Dereham outpatient's area. This

meant that should a patient's appointment be delayed they would have to leave the waiting area to get refreshments and could miss being called for their appointment.

Access and flow

- For cancer waiting times, the percentage of patients seen by a specialist within two weeks of being referred was consistently above the target of 93%, with 97.8% of patients seeing a specialist within two weeks between April 2014 and March 2015 across all specialties.
- The trust failed to meet the target for 62 day cancer care (GP referral to definitive treatment) recently, meeting 79.9% (against a target of 85%) of patients seen within 62 days within the last quarter (January to March) February was especially poor, when only 64.8% of patients were seen within the required timeframe. However the trust had seen 84.9% of patients within the last year within this timeframe (against a target of 85%). Recent delays could mean that some patients were not receiving a diagnosis and starting a course of treatment in a timely manner.
- For non-admitted patients the percentage of patients who started treatment within 18 weeks was 96.9%, this was against a target of 95%.
- There were additional "Hot Spot" clinics provided for patients who were more seriously ill. These clinics were held before or after normal clinic times in the respiratory, gastroenterology and cardiology specialties.
- Cancellation of clinics was an issue. Reasons for cancellations included staff sickness, emergency leave and staff shortages. There were 37 clinics cancelled with less than six weeks' notice in April 2015, this had affected 245 patients. There were 69 clinics cancelled with less than 6 weeks' notice in May 2015, this affected 337 patients. This meant that there were a high number of patients who were not seen at their scheduled time and we could not be assured that this had not had a negative impact on patient care. In a two month period this affected 582 patients.
- Staff told us that some clinics were overbooked, sometimes with two or three patients in one appointment slot. This meant that patients would not be seen at their allotted time.
- When a clinic had to be cancelled the trust were proactive in booking the patient into a new appointment at the time of cancellation. The clinics achieved this in the majority of cases by offering an

alternate date at time of cancellation. If the trust were unable to offer an appointment at the time of cancellation they would ensure the patient was placed on the waiting list with their original clock start time so that patients were not seen out of turn.

- The pain clinic had a waiting period of 24 weeks and the orthodontic clinic had a waiting period of 20 weeks. The trust had provided extra clinics to help reduce the backlog of patients waiting to be seen, but many patients were still waiting an extended period to be seen by a specialist.
- There was a significant problem with appointment slots issues (ASIs). For example, there was a backlog of 140 orthopaedic, 133 urology and 112 neurology patients waiting for an appointment at the time of our inspection and a total of 981 across all specialities. This meant that some patients may not receive appointments within reasonable timescales.

Meeting people's individual needs

- The department had access to a dementia specialist nurse to support patients living with this condition when they attended appointments.
- We observed an elderly, confused patient be assisted by two members of staff including a patient support worker. The patient was becoming distressed so the staff ensured she was seen in a timely manner. The staff who attended the patient dealt with her in a kind and compassionate manner although some communications were a little condescending.
- The outpatients department had close links with other local services, and the police to identify and protect vulnerable groups, for example those affected by human trafficking.
- Staff verbally informed patients of clinic waiting times however there was no robust consistent mechanism in place for patients to be updated when clinics were running late. We noted that patients were kept updated well in some clinics, but not updated in other clinics. White boards were provided for information, such as clinic delays, to be made available to patients; however these boards were not always updated or accurate.
- We were told of a patient with a learning disability that became so distressed at their appointment time they refused to leave their car. The consultant and nurse attended to the patient in the car and a verbal
Outpatients and diagnostic imaging

assessment of the patient's condition was carried out. This meant that the patient was still assessed at their appointment time and that their individual needs were catered for.

- There was seating provision for larger patients, with larger sized and increased weight capacity chairs available.
- Translators could be arranged for face to face appointments and the trust made use of "language line", a telephone translation service, if required, which staff could access on the day of an appointment.
- Patient leaflets were available in other languages, the most frequently used patient letters had been translated into Russian, Polish, Lithuanian and Latvian languages. Other languages could be produced if required.

Learning from complaints and concerns

• There were notice boards on display called "You said, We did". These boards showed how the trust had responded to concerns and complaints about the department. For example, one board showed that patients had complained that there were delays in booking in for their appointments and in response the trust had recruited another two receptionists.

- Whiteboards displaying clinic information including waiting times had been introduced as a result of patient feedback, however we noted that these were not completed in all instances and were not completely up to date in others. We spoke with one patient whose clinic was showing as running "on time" but he had been waiting 25 minutes after his appointment time.
- There were posters and leaflets clearly on display throughout the outpatients department detailing how to make a complaint and there were "share your experience" leaflets throughout the department encouraging patients to feedback to the trust, many of these forms were visible in the box as evidence that patients were communicating with the trust. Patients and relatives were aware of how to contact the trust with concerns or complaints.
- Staff we spoke with were aware of the local complaints procedure, but could not provide any examples of learning from complaints. This meant that we could not be assured that there was sufficient learning from complaints to prevent reoccurrence.

Outstanding practice and areas for improvement

Outstanding practice

- The waiting area for children within the emergency department, whilst small, was designed in an outstanding way which responsive to all children who visit the service.
- The commitment of midwifery staff to develop effective midwifery services for women from the King's Lynn area. Midwifery staff rotated throughout the service to maintain their knowledge and skills.
- Areas for improvement

Action the hospital MUST take to improve

- Ensure that medicines are stored securely at all times including those within the outpatients department, and IV fluids in the emergency department.
- Ensure that resuscitation trolleys are checked in accordance with the trust policy and resuscitation council guidelines.
- Ensure that an accurate record of each patients care is recorded.
- Ensure that the staffing is in line with national guidance. Examples include but are not exclusive to: registered children's nurses in the emergency department, patients requiring non-invasive ventilation, paediatric staff on the children's ward, endoscopy medical staffing, midwives in maternity and staffing on the neonatal intensive care unit.
- Ensure that there is a robust governance system to assess monitor and improve the quality of services especially in respect of decontamination of flexible cystoscopies, clinical outcome data within maternity services and the management of ASIs (Appointment Slot Issues) within outpatients.

Action the hospital SHOULD take to improve

• Review the clinical pathways especially for fractured neck of femur between the ED and the orthopaedic service and within the maternity and gynaecology services as highlighted in this report.

• Relatives and staff told us the paediatric team were a well organised and effective team who provided a good service for the children and families of the Kings Lynn area.

- Ensure a system of clinical leadership developed for all areas of the maternity service with clarity about the role, responsibilities and reporting relationships. A strategic vision should be developed.
- Should ensure that infection control practices are adhered to at all times in the emergency department.
- The hospital should develop a joint clinical and managerial response to the review carried out by the royal college of obstetricians which provides a clear strategic vision for the service
- Ensure staff training for patients living with dementia is effective in practice, and that staff can recognise the need and complete the patient passport where necessary.
- Ensure the operational management structure is established and known to all staff within each service
- Access to medical staff on call should be improved across obstetrics and gynaecology to ensure patients have timely access to medical advice
- Develop the role of the PAU in response to the needs of the population
- Ensure incidents and complaints relating to end of life care are easily identified and a process is in place to ensure learning is identified and used to influence the development of the service.
- Ensure the cancellation rates and specialty clinic waiting times in the outpatients department are reviewed and improved.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The trust must ensure good governance procedures are in place as we found:
	Cystoscopes were not always decontaminated in line with national guidance.
	Clinical data was not robustly collected in maternity services in order to improve services.
	The management of appointment systems in the out patients department did not always meet peoples needs.

Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The trust should ensure that services are safe and that patients receive appropriate care as we saw that:

Medicines were not always stored securely at all times including those within the outpatients department, and IV

fluids in the emergency department.

Resuscitation trolleys were not always checked in accordance with the trust policy and resuscitation council

guidelines.

Accurate records are kept of each patients care.

Regulated activity

Regulation

Requirement notices

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Maternity and midwifery services

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The trust is failing to comply with this regulation as we found that:

There were not sufficient children's nurses in the accident and emergency unit.

Patients requiring non invasive ventilation were not always cared for in line with national guidance.

There were not always sufficient paediatric nurses on duty in the children's ward.

The endoscopy on call rota was not staffed by staff on a rota but relied on the good will of consultant staff.

There were insufficient nurses in the maternity unit for the number of births occurring at the unit.

Staffing on the neonatal unit was not always sufficient to meet the needs of patients.