Norfolk and Norwich University Hospitals NHS Foundation Trust

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Quality Report

Colney Lane
Colney
Norwich
Norfolk
NR4 7UY
Tel:01603 286286
Website:www.nnuh.nhs.uk

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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.

Summary of findings

Letter from the Chief Inspector of Hospitals

The Care Quality Commission (CQC) undertook an unannounced responsive inspection between 4th and 6th March 2015. The inspection rationale related to an increase throughout 2014 of negative intelligence regarding various areas within the Trust. Therefore the inspection focused specifically on accident and emergency services, capacity and demand, medical care and cancer services, surgery, and overall leadership of the trust. As this was a responsive inspection there are no ratings attached to our findings.

The hospital was opened in late 2001 having been built under the private finance initiative (PFI). The Trust provides a full range of acute clinical services plus further private and specialist services. The Trust has 1099 acute beds and It provides care for a tertiary catchment area of up to 822,500 people from Norfolk and neighbouring counties. The hospital also has an important role in the teaching and training of a wide range of health professionals in partnership with the University of East Anglia, University Campus Suffolk and City College Norwich.

Previous inspection by the CQC took place on the 2nd and 3rd December 2013 and had resulted in one compliance action in respect of Regulation 17 HSCA 2008 (Regulated Activities) Regulations

2010 Respecting and involving people who use services.

Since Qu2, 2014 the Trust has been breaching on national targets, ED waiting times, Cancer services and referral to treatment time. This has increased pressure on the leadership and staff teams to meet targets and raised concerns that patient care may be affected.

Our key findings were as follows:

- Capacity and demand was an issue for the Trust and there were a high number of delayed transfers of care. It was evident that the lack of community provision was a contributing factor. Escalation areas had been opened in response to capacity demands however plans were not yet well established in terms of ensuring a longer term improvement strategy for capacity and demand.
- The trust had taken action in respect of capacity management in the emergency department on a day to day basis however a cohesive strategic plan for access and flow of patients was lacking.
- Leadership within the Trust is fragmented and the capacity and target pressures have led to the Board being too operationally focussed and reactive resulting in an inconsistent management approach to staff at a local level
- On the Acute Medical Unit (AMU) staff were unclear regarding best interest decisions and of their responsibilities under the Mental Capacity Act 2005.
- At the time of our inspection, there was no evidence to demonstrate that any patients had suffered an adverse clinical outcome due to breaching cancer waiting times. However, there was a significant risk of emotional impact for those people not receiving treatment within specified guidelines. An improvement in performance had been forecast but we were not assured sufficient plans were in place to ensure sustainable improvement.

There were areas of improved practice:

- The trust had completed and implemented an action plan with regard to the compliance action and significant improvements had been made. We judged that the Trust was now meeting this requirement and therefore have removed this compliance action.
- Following a serious incident in 2014 regarding VTE risk assessment and treatment in patients undergoing day surgery the trust had put an action plan in place to address concerns arising from this incident. We found that this action plan had been completed appropriately and that learning and improvement had taken place.

The trust needs to make the following improvements:

Summary of findings

- The trust should ensure that there is a clear strategy to improve patient access and flow through the emergency department and that there is a consistent management approach in response to high demand pressures.
- The trust should ensure that all staff receives training on the mental capacity act and that this is continuously monitored.
- The trust should consider how it can demonstrate clinical decision making in those patients records who are admitted to Mattishall Ward.
- The trust should consider how it can demonstrate and provide assurance that improvement to cancer services and demand for services will be sustainable.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services		Systems and processes were in place to promote safe care. Major incident emergency plans were in place. Patients received care and treatment based on Evidence based standards with trauma care comparing well against the region. Effective and consistent levels of staff were available 24 hours a day, seven days a week. Patients and relatives were positive about the care they had received. We saw that staff provided compassionate and respectful care. The department was not consistently meeting the four hour waiting time target for emergency departments. This was due to the flow of patients through the hospital overall. Patients in the emergency department (ED) were provided safe care while awaiting transfer or discharge. Leadership and management of the emergency department was good. However, we found pressure was applied by executive staff to manage the service in ways not agreed by department staff. Medical and nursing staff were committed to improving clinical care and patient management. Staff were supportive of building plans to improve facilities and capacity.
Medical care		Overall the areas we visited within the medical services directorate were meeting requirements. Information was provided as to how the environment within Mattishall ward had been developed over previous months. However at the time of our inspection, improvements were still required. The layout of the ward was not appropriate being openly accessible to the clinical trials unit located directly next to it. Equipment was not fixed, a sluice was shared and staffing was not permanent. A plan was in place to completely renovate the area into a fully compliant and permanent ward area. However these plans were in their infancy and timescales had not yet been agreed. Although there had been problems with the provision of service when the Henderson Unit first opened for example, closing on Christmas day due to lack of staff,

Summary of findings

this was acknowledged by staff to have been due to lack of initial planning and haste in opening. The service had recently begun to run more efficiently and plans were in place to develop and improve the service.
In 2013 the trust was found to be non-compliant with requirements in ensuring people were respected and involved in their care and a compliance action was issued. The service had completed and implemented an action plan and significant improvements had been made. We have therefore removed the compliance action and judged the trust to be meeting this requirement.

Surgery

At the time of our inspection the service was not meeting performance targets in relation to cancer waiting times. Whilst patients who had not been seen within specified timescales were being monitored, we were not assured sufficient plans were in place to ensure sustainable performance improvement.
There was a serious incident in 2014 regarding VTE risk assessment and treatment in patients undergoing day surgery. The trust had put an action plan in place to address concerns arising from this incident. During this inspection we reviewed the improvements made and implementation of the action plan. We found that this had been actioned appropriately. This demonstrated learning and improvement had taken place.

Norfolk and Norwich University Hospitals NHS Foundation Trust

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care); Surgery; Services for children and young people.

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Detailed findings

Background to Norfolk and Norwich University Hospitals NHS Foundation Trust

- The Norfolk and Norwich University Hospital is an established 1000 bedded NHS Foundation Trust which provides acute hospital care for a tertiary catchment area of up to 822,500 people. Acute hospital care means specialist care for patients who need treatment for serious conditions that cannot be dealt with by health service staff working in the community.
- The Trust provides a full range of acute clinical services, including more specialist services such as oncology and radiotherapy, neonatology, orthopaedics, plastic surgery, ophthalmology, rheumatology, paediatric medicine and surgery.
- The Care Quality Commission (CQC) undertook an unannounced focused inspect between 4 and 6 March 2015. Prior to this inspection the CQC had received a number of whistleblowing concerns, patient complaints and contact from the local health economy regarding the functioning and performance of this trust. This inspection was therefore undertaken to follow up on those concerns which had been raised with us and focused specifically on accident and emergency services, medical care and surgery, and overall leadership of the trust.

Our inspection team

The team included two inspection managers, two inspector and two specialist advisors. One specialist was an experienced gynaecological surgeon and the other a nurse with extensive ED experience.

How we carried out this inspection

1. Prior to this inspection, we reviewed information which was held by us in relation the areas being inspected.

2. We undertook an unannounced site visit between 4 and 6 March 2015.

3. We talked to a range of staff and patients.

4. We reviewed data provided by the trust following our inspection.

Facts and data about Norfolk and Norwich University Hospitals NHS Foundation Trust

<This information should be taken from the context section of the data pack>

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	N/A	N/A	N/A	N/A	N/A	N/A
Medical care	N/A	N/A	N/A	N/A	N/A	N/A
Surgery	N/A	N/A	N/A	N/A	N/A	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Notes

<Notes here>

Urgent and emergency services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The Emergency Department (ED) at Norfolk and Norwich University Hospital provides a 24-hour, seven day a week service to the local area. The department was originally built for 60,000 attendances but is currently seeing in excess of 100,000 attenders of which approximately 25% are children. From October 2014 to December 2014 there were 27,289 attenders to the ED. The trust had recently introduced a single point of access reception which triaged patients into the urgent care centre (UCC) operated by a separate provider. This had reduced the pressure on ED as there were approximately 30 patients each day diverted to UCC.

Patients presented to the department either by walking in via the reception or arriving by road or air ambulance. The department had facilities for assessment, treatment of minor and major injuries, a review area which consisted of three bays for patients awaiting transfer to the ward, a resuscitation area and a separate children's area.

Our inspection included two days in the emergency department as part of an unannounced inspection. During our inspection we observed care in the clinical environment and spoke with patients, medical and nursing staff. This included eight members of the medical team, 15 members of the nursing team, and 16 patients.

Summary of findings

We found that systems were in place to maintain patient safety. There was effective use of incident reporting and learning from investigation. Staff maintained good infection control and prevention procedures and equipment was well maintained and checked routinely for safe operation. Medication was stored securely and there were effective processes for safe administration of medications. Staff were aware of safeguarding procedures and record systems were in place to identify safeguarding issues.

Urgent and emergency services

Are urgent and emergency services safe?

Nursing and medical staff levels had been reviewed and were adapted to meet the demands of patients attending the department. There were several separate areas in the department where staff provided supervised care to patients which required minimum staffing levels to be adhered to in order to ensure patient safety. Increased staffing had been approved by the trust and recruitment was ongoing to meet the revised established staff level. There were agency and bank nursing staff in use throughout the department. Temporary staff were booked on a block basis which ensured a level of consistency for the team. Senior and junior medical cover was provided in line with national guidelines with locum medical staff in place when required. There was consultant medical presence in the department each day and registrar cover from midnight.

Incidents

- Incidents were reported on an electronic reporting system. Staff were aware of the incident reporting system and all staff we spoke with how to report incidents. The data demonstrated that there was regular reporting of incidents by staff. There were 890 incidents reported in the 12 months to January 2015, ranging from 56 to 100 per month.
- Incident reports were reviewed by an emergency service consultant or the senior matron depending on whether the incident was either a medical or nursing issue respectively. There was one senior nurse allocated on a daily basis to review any incidents reported and flag any serious incidents (SI) as a priority which meant that incidents were reviewed in a timely manner. We examined the reports of two investigations and saw that learning was identified and recommendations for clinical practice or management were set for the teams in ED to be followed up by named member of staff.
- Some staff stated that there was not always time to complete an incident form and that information and outcomes following a report were not consistently fed back, this meant that not all staff were aware of learning outcomes following a reported incident. Learning from incidents was communicated to staff through the team meetings, the staff noticeboard and emails to all staff. There was a plan in place to begin “lessons of the month” following incidents to attempt to improve the feedback communication however this had not yet started. We saw that there was a learning point displayed in the staff room
- Mortality and Morbidity meetings were held monthly to review cases. We spoke with the consultant who managed clinical governance for the service. We saw reports on two specific cases that had been discussed at governance meetings.

Cleanliness, infection control and hygiene

- The department was clean and staff were aware of infection control procedures including the use of personal protective equipment.
- Two additional treatment bays had been established in the major’s area. Hand gel dispensers had been made available in these bays and in the corridor assessment area, as there was no sink in these additional spaces. A sink was easily accessible in the centre of the major’s area enabling hand washing to take place. There was good access to protective gloves and aprons in all clinical areas.
- There was one room and two bays within the initial assessment unit (IAU) that were identified for patients with infection risk such as diarrhoea and vomiting. This enabled isolation of such patients to try and reduce the risk of the spread of infection, and cleaning without disruption to other bays.
- Infection control audits were completed as part of departmental audit checks. Results showed that staff were adhering to guidance and policies. Audit data demonstrated there was 100% achieved for hand hygiene and dress code audit from February 2014 to January 2015.
- Training records for the year ending December 2014 indicated that of 152 staff in the nursing team in the ED, 54 (35%) had not attended their required update training in infection prevention and control. This was an indication of operational pressure on the ED however we observed staff followed infection control guidelines, for example, hand washing.
- There had been no cases of MRSA or Clostridium dificile attributed to the emergency department from February 2014 to January 2015. Screening was completed in ward areas at the point of admission. Patients being admitted to the accident and emergency department with a known infection would have an alert raised from the electronic patient record system.

Urgent and emergency services

Environment and equipment

- Equipment in the resuscitation areas and main department was maintained, stocked and checked ready for use. There was a checklist book showing that all key trolleys and equipment had been checked each day.
- Resuscitation equipment such as airway equipment was laid out in packaging ready for use and in drawers available for rapid access. Airway equipment was clearly labelled and photograph reminders were in place inside drawers to ensure all equipment was present.
- New patient trolleys had been purchased for the accident and emergency department. Ten trolleys had been added in recent months. Patients were nursed on trolleys which were in a good state of repair and had soft mattresses which were designed to prevent pressure ulcer development. Patients told us they were comfortable on these emergency trolleys.
- The emergency department had created additional nursing bays for patients by removing some partitions and rehanging curtain tracks. This meant patients were closer together but staff were aware of this and maintained privacy as far as possible. Extra monitoring and emergency equipment was in place for these additional areas.
- Curtains to the front of bays were left open in most cases to facilitate observation by staff. Staff were very aware of dignity of patients and when examining patients' curtains were always drawn.

Medicines

- We checked controlled drugs in the resuscitation area and saw they were recorded appropriately when administered, and stock levels were checked and correct.

Safeguarding

- There was a safeguarding lead within the department who provided training to staff.
- All staff within the ED completed mandatory safeguarding training to level 3. Training records confirmed 82 % staff had completed child safeguarding and 70% had completed adult safeguarding training for the current year, ending March 2015.
- There was a separate sheet for completion on all patients under 18 years old by the doctor or specialist nurse who examined them. Information was shared with the trust safeguarding team or paediatric liaison nurse.

Mandatory training

- The department had one senior nurse who was the education facilitator who worked 30 hours per week and managed and maintained staff training and education. There was evidence of a structured education programme with mentor groups identified however these days were at a risk of cancellation due to the level of the department activity.
- The mandatory training data showed for April 2014 - March 2015 74% staff had completed equality and diversity training, 78% information governance, 85% medicine management and 81% resuscitation training.
- Separate training sessions were provided by various specialist nurses. For example, the bereavement lead and spinal injury lead provided training sessions within the education programme.
- New staff were allocated a buddy for support and were supernumery within the team for the first two weeks. They were then allocated to one area for six months, (normally trolley bay or resus), which were the two areas where there were always more trained staff to provide support. This provided some consistency and was to ensure supported learning.

Assessing and responding to patient risk

- Initial assessment and management of patients was undertaken for minor injury patients by triage nursing staff. These were experienced staff who had also undertaken triage training. Triage was completed as soon as possible after patients had registered. Some patients who walked in were assessed as being suitable for treatment by GPs in the urgent care centre (UCC) in the building.
- Patients who required major assessment and treatment who may have arrived by ambulance were assessed by nursing staff and an emergency consultant in four dedicated treatment bays. This enabled rapid decision making about the best patient pathway including referral to specialist medial teams or management in the emergency unit. The initial assessment process enabled rapid identification for urgent diagnostic tests or urgent treatment where needed.

- The area for patient assessment in the corridor where ambulance cases arrived had been risk assessed and a standard operating procedure was in place and displayed in this area. The maximum number of patients within this area was eight. Following risk assessment the area was managed with a minimum of one registered ED nurse and one health care assistant. These numbers were increased in response to patient activity. One member of staff remained present in the corridor at all times. We observed this was the case with staff being redeployed as needed.
- Staff had access in this area to the information system showing patients expected by ambulance and the waiting time status of patients in the ED.

Management of deteriorating patients

- We saw that an early warning score (EWS) was being used to check for patients that might be deteriorating. EWS is a guide used by nursing and medical staff to quickly determine the degree of illness of a patient. Staff making observations used any changes in the score to escalate to senior staff for review of the patient. Health care assistants told us there was a clear system for escalation using the score. This was being used in the corridor assessment area to identify any patients that may need moving more rapidly into a treatment area. Scores were displayed on team boards as part of the routine monitoring for waiting patients.
- Information displayed in the staff area regarding performance did not include audit results for the EWS.This meant that senior staff could not tell how consistently the system was being applied.

Nursing staffing

- Nurse staffing requirements were agreed by the Trust and this meant 23 registered nurses available on the day shift, 9am to 9pm. This was consistent with staff rotas we reviewed. An increase in staffing had been achieved by recruitment and by some block booking of agency staff to provide continuity. The emergency department nursing staff had implemented arrangements where there were nominated staff to cover a corridor assessment area.
- Staffing in the assessment area corridor had been reviewed. On every shift there were three allocated (identified) trained staff to this area with one healthcare assistant for support. When the corridor was quiet staff were allocated into teams within other areas in the department and were redeployed to the corridor when activity increased. This meant that there was a knock on effect to other services depending where the staff were working. For example one IAU bed or the pre assessment area would close to allow the staff to redeploy to the corridor. There was no audit or measure in place to ascertain impact on other areas when this occurred.
- High levels of agency, bank and over time were in use at the time of inspection. On 4 March 2015 staff numbers included six agency on the early shift and five agency staff on the late shift out of a total of 23 trained staff (26%). Some agency staff required supervision as they were new or unfamiliar with the department. Where four or more agency staff were on a shift this had been difficult for the regular staff to maintain consistent support.
- Some staff were due to relocate due to changing roles which would mean more pressure on staff levels in the department. Some staff were moving to UCC which supports ED by accepting and treating patients who walk in to the department.
- Communication and identification of employment and competency checks for agency staff was identified as a risk by senior nursing staff. An agency nurse would arrive for a shift and the nurse in charge had no system in place to assess quickly their competency and review evidence of their extended skills. During our inspection a check list of named agency staff with checks and skills was developed and put on display in the sister's office to enable staff on duty to check and gain reassurance.
- Nursing handovers were comprehensive, relevant and included patient waiting times and key risks such as pressure areas This communication ensured continuity of care and patient safety between different staff following shift change

Medical staffing

- There were eleven consultant medical staff in the emergency department. This meant that there were two consultants present during the day from 9am to 12 midnight seven days a week. For the rest of the night there was a registrar present for the emergency department with the support of three junior grade doctors. We judged this was safe staffing level as it

provided for a registrar presence through the night for senior decision making about patient issues, and enabled the different parts of ED to be supported by medical staff.

- We examined the rota for medical staff for the three months November 2014 to January 2015. This showed that shifts had been covered to ensure senior medical staff available at all times.
- Between November 2014 and January 2015 the trust's own consultant staff had covered 11 consultant shifts due to a combination of sickness and a vacancy. The Trust's own consultant staff also provided a number of planned additional shifts over this period to cover times of anticipated high demand. This had been reduced from 2014 levels with appointments to substantive posts on the medical team. Three additional consultant posts had been agreed by the Trust and advertised.
- The consultant lead for the ED was a consultant in elderly care medicine who had been in the position since August 2014. Appraisal, training and on call rosters had been improved and were now appropriately managed. Documents showed the organisation of these areas of local management of the medical team. There was annual appraisal of medical staff and sickness absence was managed appropriately. Consultants had lead roles in the team with consultants taking responsibility to manage audit, governance or training responsibilities, including leading on trauma care.
- Within the medical team the consultants undertook different levels of cover. Only eight of the 11 participated with the on call rota. There was consultant cover from 9 am to midnight, after which provision was one registrar with three juniors. There was a plan to have a second registrar out of hours. At the time of inspection there were three registrar vacancies being advertised and we were informed that it was a struggle to recruit registrars.

Major incident awareness and training

- There were clear up to date major incident plans available to staff in the ED. Identified medical and nursing staff were responsible for training and maintenance of equipment stores for major incidents. Incident plans had been tested in part when there was a need to deploy additional staff and act to manage periods of high activity through the winter period.

Are urgent and emergency services effective?

(for example, treatment is effective)

The ED staff used clear protocols to manage patients. There were standard systems to ensure trauma patients received urgent specialist attention. National benchmarking audit showed that trauma patients attending the ED were cared for effectively.

There was good multidisciplinary working including working with ambulance staff to manage the safety of patients at all times. Competency of staff was monitored and assessed with nursing staff only taking responsibility for key roles, such as minor injury triage or assessment nurse for patients arriving by ambulance once training had been completed. Similarly medical staff competency framework meant that technical procedures were only performed by those doctors appraised as competent.

Staff described they acted in the best interests of patient's. However, we found there was poor awareness of the use of clear processes and trust documentation to assess mental capacity and this could affect the validity of consent.

Evidence-based care and treatment

- We discussed with staff in ED about management of trauma patients. There was a clear trauma team system in place with calls made to summon specialist staff from other parts of the hospital. The trauma team leader protocol ensured a consistent approach to management of trauma patients.
- Handover of patients to other departments was based on a standard tool: a situation background assessment recommendation (SBAR) used to communicate the needs of critically ill patients.
- Nursing staff were identified into teams with a team leader for each role displayed on the white board. Intentional rounding took place to ensure patient's needs, such as pressure area care and nutritional needs, were monitored throughout their stay within ED. Rounding checks were noted on the team wipe boards in the clinical area; this meant that staff had a visual reminder to undertake the routine checks.
- There was no audit taking place to either monitor or measure the effectiveness of intentional rounding which meant that consistency could not be assured.

Urgent and emergency services

Pain relief

- We spoke with five patients about the management of their pain. Three patients said they had been provided with pain control medication by the nurse and this administration was through the use of a patient group directive. This meant the patient's condition and pain was assessed and managed using clear criteria and without having to wait for the doctor to attend. All five patients said their pain was managed well. Two patients told us they had been given pain medication by ambulance staff.
- Nursing teams regularly asked patients if they were comfortable and their pain was being managed.

Patient outcomes

- There was a benchmarking report of trauma care at the Trust. The Trauma Audit and Research Network (TARN) data noted that survival rates of patients attending with severe traumatic injuries at 2.8 additional survivors per 100 patients for the year 2013 – 2014 which was the best performance in the region.
- In the three months October to December 2014 of 27,289 patients attending ED there were 424 (1.55%) patients in ED for between four and twelve hours from decision to admit to admission. which was less than the overall national average for the same period of 1.62%.
- Results of quarterly audits were displayed on the matron's notice board within the staff area. Data showed 100% compliance for the cannula care audit.
- An external company were due to come into the ED in March to give assistance on data capture to improve audit collection. The staff informed us that they were planning to audit and review the impact of the initial assessment unit (IAU) process.

Competent staff

- Nursing teams included specialist emergency practitioners who were able to manage patients with minor injuries without the patient waiting for the doctor. There were nursing staff that were continuing studies to advanced practitioner and masters level.
- A competency framework was in place for medical staff. Documentation for this showed that all medical staff followed a system to ensure competency in specific emergency medical procedures such as managing various types of trauma, eye conditions, dealing with airway emergencies and emergency techniques for administering fluid to patients in shock.
- Medical staff had competency assessed in stages before being able to perform procedures without supervision. This meant the procedures were performed by staff with appropriate knowledge and practical competence.

Multidisciplinary working

- The ambulance service had a hospital ambulance liaison officer (HALO), working 12 hour shifts in the department. This was a senior paramedic or ambulance manager to assist with the ambulance handover process.
- The urgent care centre situated adjacent to the ED department was staffed until 10pm and took approx. 30 patients a day from the ED. There was a physiotherapist and occupational therapist available between 8am and 8pm.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were not fully aware of process or documentation when assessing mental capacity. This is important where procedures may be required but the person does not have the capacity to consent.
- Staff advised that medical staff make a judgement about mental capacity and this is recorded on the clinical notes along with discussion about consent with relatives where needed.
- Staff noted that where emergency care was required and in collaboration with relatives they would act in the patient's best interest. Staff were not sufficiently aware of the relevant forms that may be used to record mental capacity.
- The trust safeguarding lead was able to locate forms on the intranet for use to record mental capacity but no staff in the ED advised they were aware of the form. This could mean that there was a risk patients would receive treatment without consent in place.

Urgent and emergency services

Are urgent and emergency services caring?

Patients and relatives were positive about the care they had received. Staff gave care that was delivered in a kind and considerate manner taking into account the clinical and emotional needs of each person.

All staff respected the dignity of patients and also maintained good observation of ill patients. Patients' anxiety was managed with compassion, and the majority of patients were kept informed of the progress of their care and treatment.

Compassionate care

- We spoke with nine patients about the compassion of nursing staff. They said that staff were "kind and efficient", and had reassured them by advising of the process of admission or review by clinical staff. One patient was pleased as they had received assessment and initial tests within an hour of admission.
- One patient was alone in a separate assessment room, which had an emergency bell for staff to raise an alarm but no patient call bell. When asked how they would summon help they said that they would shout. Staff stated patients were assessed carefully before being placed in this room and during our inspection all patients who were in this room were suitable to be there.
- One patient had been brought in by ambulance and was assessed within a bay in majors. The patient was alone and the curtain had been left open to ensure the patient could see staff. When we spoke with the patient they had received some information from the staff. However, the patient was unsure what the situation was and said they were "now just waiting for staff to come back and see them."
- Within the urgent care centre there were cars and staff available to transfer patients home. One patient was taken home by car during our visit. This system helped to facilitate discharge and provided support to patients.
- Handovers were not always completed beside the patient which would enable staff to introduce the new nurse on shift. However nurses introduced themselves clearly when entering treatment bays.

Understanding and involvement of patients and those close to them

- We asked five patients if they had been given sufficient information. All patients and the relatives with them in the bays told us they had been advised by the nurse of the expected wait and what was happening in their care.

Emotional support

- Patients said the nursing staff were helpful and kind. One patient explained they were waiting for a final check of blood pressure before they were allowed to get up off the trolley to go home.
- There were two relatives rooms available to enable staff to be able to give support and information in private.
- There were a wide range of patient information leaflets which were displayed and available in the triage area.

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

The trust has not been achieving the target to manage patients within four hours of attending the ED. This has been due to significant increase in patient activity and the inability of the hospital service overall to maintain a flow of patients away from the ED into ward areas.

Staff in ED had established ways of working to manage demands on patient flow. This meant patients were managed safely while awaiting transfer. Patient assessment has been accelerated through the use of initial assessment and some patients being diverted to an urgent care centre staffed by GPs.

Staff were reactive to the increase in patient attendances but forward planning for discharge was not embedded. Strategic planning to manage seasonal peaks in activity had been ineffective in promoting the flow of patients through to hospital wards from ED. Some additional ward beds had been allocated to deal with escalation of activity for the seasonal increases in patients but this had proved an insufficient response by the Trust. ED waiting times had remained worse at 88%, when compared with the target of 95% of patients to be seen within four hours of arrival.

Service planning and delivery to meet the needs of local people

- Concerns were raised by the East of England Ambulance Service NHS Trust (EEAST) regarding delays with patients being received into the department. This

resulted in a directive from EEAST that handover must occur within a maximum of 30 minutes with a short deadline to implement. In order to support this, the department had identified a trial process.

- The amount of bays in the major's area had been increased from 15 to 18 in total. The children's area had been increased from two to four bays by converting a soft play area. An area in the corridor had been identified for ambulance patients awaiting handover or for patients who had been handed over and were awaiting assessment. This area had three curtained trolley bays and space for five trolleys, giving a maximum space for eight patients.
- The minors area and urgent care centre was due to relocate at the end of March 2015 which would have an impact on the flexibility of staffing but building work was not complete. Currently staff were reallocated to help in majors during high activity.
- The trust has collaborated with the community trust to provide a walk in service in the same building for patients attending ED who are judged suitable to be managed by a GP and therapy staff. This meant that people were seen according to their needs and waiting time was reduced for all categories of patients.
- The trust had longer term plans for rebuilding of the ED. The plans included improvement in paediatric facilities and increased number of treatment bays to manage the increased flow of patients through the service however a timeframe for this was not specified.

Meeting people's individual needs

- To manage the needs of patients arriving with urgent care needs there were four bays used as initial assessment unit (IAU). This was operational 9am - 9pm seven days a week. IAU was a nurse led assessment with a consultant allocated to support and facilitate early decision making about discharge or specialist care on admission.
- Handover between the ambulance crews and assessment staff took place in the corridor assessment area. Throughout the inspection the activity in this area varied with patient numbers ranging from one to eight. Space was very limited and, in busy periods, it was not possible to maintain privacy due to the close proximity of other patients.
- There was not adequate consideration for patients with dementia Staff attending one patient with dementia told us they felt the environment was unsuitable for people living with dementia and in particular that the waiting time was causing additional disorientation. There had been no prioritisation for this patient to acknowledge this factor in addition to the patient's physical needs.

Access and flow

- The Trust had not been achieving the waiting times target for patients waiting in the accident and emergency department. In the three months October to December 2014 of the 27,289 patients attending accident and emergency 88% were admitted, transferred or discharge within four hours against the national target of 95%.
- The emergency department had escalation procedures in place to notify the site managers and executive team when additional workload meant that patients will be waiting over four hours to complete treatment or be admitted. Escalation procedures were available for quick reference to staff on laminated sheets in the emergency department.
- To manage flow through the hospital the department had access to ambulance transfer information showing expected patients. In addition, the department based ambulance liaison officer worked with emergency department staff to predict workload hour by hour. Site managers also attended the department to assess with emergency staff the imminent demand on hospital beds and, they worked together on planning admissions to hospital wards. The consistency of application of this was variable. Staff in the emergency department and site managers we spoke with noted the difficulty with finding beds in hospital wards for patients moving from the ED. When there was likely to be a high demand of patients waiting in the emergency department the issue was escalated to the trust director on call.
- There was adequate communication of increased demand from the ED. All cases of patients being in the department for four hours were recorded on a breach form and the causes of this were notified to the executive team for the trust.
- There was an IT system in use to identify patients within the department which included data on the time of admission and gave a live update of the time left for each patient. Any patients who had breached the four hour target of waiting time in ED were easily identified on the system by a colour code (purple).

Urgent and emergency services

- The Trust and emergency department had implemented changes to processes and use of space to manage additional patients through the department. There was a review area which consisted of three bays for patients awaiting transfer to the ward. There were standard operating procedures in place for this area.
- The emergency department was using a corridor area as an assessment area. This area had three curtained trolley bays and space for five trolleys, giving a maximum space for eight patients. This was to facilitate hand over of patients from ambulance service into the care of the hospital staff when the other main treatment areas were full. This therefore allowed a timely return by ambulance staff for availability to other emergency calls.
- The Trust had implemented additional bed space in two ward areas to manage seasonal pressures but it was felt by emergency staff that this had not been sufficient response to the additional workload. Staff told us that the flow of patients through the hospital system was a key factor in not meeting the ED waiting times target.
- The trust had worked with community trust to develop the urgent care centre service. Staff from this service worked with emergency department staff to screen patients arriving at the main accident and emergency. Suitable patients were offered the option to be seen by a GP in the urgent care centre in the same building. Staff told us that approximately 30 patients per day were being treated by this service rather than wait for treatment in ED
- Space was limited in the minor injury assessment area. There were two bays with curtains provided for privacy. However, there was no ability to soundproof so discussions could potentially be overheard by another patient when both bays were in use at the same time. This, however, would be addressed by the planned move of the minors area at the end of March 2015.
- There was a separate entrance for ambulance admissions. There was also a separate entrance to the resuscitation bays and landing facility for helicopter arrivals which facilitated access and speed for seriously injured patients.
- There was an area in the corridor that was in use for ambulance patients awaiting handover or for patients who had been handed over and were awaiting assessment. Nurse's maintained dignity and comfort in the corridor area by ensuring patients were covered appropriately. Patients were moved, "swapped" between this corridor area and those patients who had been assessed within the area dependant on patient need. Patients were moved out of this corridor area as soon as possible.
- On two visits to the department most or all trolley 'spaces' in the corridor were being used but within two hours the area had been cleared again with patients moved into the main curtained treatment cubicles. This was despite there having been patients waiting on ambulances for a short period also.

Trust wide management of patient access and flow

- The operation centre base was staffed by the site team. There were two site practitioners that assisted with medical bed allocation by undertaking hourly rounds to the wards checking on bed status throughout the day.
- There was a review by the matron responsible for medicine and operation centre matron at 8:30am, 12 midday and 4pm with updates then given to the executive director on site and the medical director. These reviews were driven around the provision of nursing care needs. Input from senior clinicians was variable as this was only sought at very critical periods to facilitate patient discharges and flow.
- There was a computer link in the operations room which indicated the hourly flow through the ED. Numbers were transferred from this computer by hand to a white board, which was updated every two hours which was time consuming and open for errors. There was no administrative support staff which meant this was undertaken by the site matrons.
- At times of severe bed crisis across the region the computer system that was linked to ambulance service displayed the flow of ambulances to all hospitals. This meant that hospital Trusts and the ambulance service could work together to manage overall demand. However staff in the ED stated it was unusual for any ambulances bound for their hospital to be diverted.
- ED staff had identified patient flow as a risk and this was reflected in the risk register.

Learning from complaints and concerns

- There was a monthly report from the friends and family test which was communicated via email and by display on the notice board in the staff room.
- Recent complaints had been around waiting times and uncomfortable chairs within the waiting area. Chairs

were standard hard chairs throughout the waiting area. There were no chairs of different sizes or comfort which would be suitable for people who have difficulty with low chairs
- Patient feedback post boxes were observed in the department. There was a token system also in place for feedback however this system was being withdrawn in line with national guidance to be replaced by a permitted written feedback system.

Are urgent and emergency services well-led?

We found there was good local leadership of the ED with medical and nursing leaders ensuring appropriate monitoring, supervision and support. Continual pressures on the ED service due to difficulty of flow through the hospital were affecting staff morale. An NHS Emergency Care Intensive Support Team review had been completed in December 2014. Recommendations from the review were being implemented.

We heard on a number of occasions that decisions about the running of the department were made by the trust executive. ED staff that we spoke with said they felt that these decisions were being made without adequate consideration of concerns they raised. This had a further effect on staff morale as they did not feel well supported by the Trust. This was compounded by insufficient response by the Trust to seasonal pressures affecting the efficient flow of patients through ED.

There were plans to increase capacity which would enable improved accommodation, comfort and observation of patients. Staff had taken good practice from other ED's to improve initial assessment and flow of patients , for example the initial assessment unit process had been adapted from systems at Nottingham ED.

Vision and strategy for this service

- There were plans for redevelopment of the physical layout for the treatment areas of the emergency department . This development was in response to increasing demand on the service and the intention to improve specialist treatment in the service. Plans included areas for paediatric care, and defined areas for emergency nurse specialist to manage patients.
- An NHS Emergency Care Intensive Support Team review had been completed in December 2014. The review team made 18 recommendations for the ED ranging from the management of patient initial assessment and flow by triage and shift coordinator staff, to the remuneration of agency staff and the management of patients with mental health needs. The department and Trust managers had developed an action plan which was being implemented. For example, there were clear command and control arrangements with an ED consultant allocated for this and for initial assessment bays.

Governance, risk management and quality measurement

- Local audits were undertaken regularly within the department. The medical staff of the ED audited clinical processes and outcomes for specific conditions such as audits of the care for children having seizures were made. Learning from incidents had also enabled an improvement in safety through clear protocols regarding admission in such cases. Other audits we saw include asthma care and management of fractures.
- Trauma audit was undertaken and submitted for national benchmarking. Data for 2013 -14 showed the Trust had the best survival rates for trauma patients in the region.
- Trauma audit results were also used to review the time taken for reporting of emergency CT scans in 2014. The average report time was almost one and a half hours from scan to reporting. The results were used in discussion with the diagnostic imaging department. Data was not available to evidence any improvement.
- Information governance meetings took place monthly with information fed back by the ED consultant and education facilitator . We saw that there was a generic template which structured the meetings but staff said that this was restrictive and they had to "shoehorn information into a template".

Leadership of service

- There was effective local leadership in the ED with staff advising us of good support and organisation by their manager. There was an open door policy to the sisters within the department for the junior staff.
- Support from the hospital clinical operations centre was variable with some managers trying to apply decisions that were not considered safe by ED team such as

additional escalation areas or splitting bays to accommodate extra beds. Senior nursing staff had refused to compromise but there was a risk that more junior or less experienced staff would be pushed to accept unsafe working.

Culture within the service

- The morale of staff within the department had been variable. It had improved slightly as higher staff numbers had reduced some stress.
- Escalation of concerns in ED was to the senior Matron. Staff informed us that they were confident with escalating at this level and felt supported. However the culture and support from a higher level was not good and there was not an open culture within the Trust. Senior staff in the department also told us they "had a limited voice." Issues could be raised with the senior Matron and Lead Consultant but then nothing further would happen with no information feedback when actions were not taken. Only two staff members out of fifteen told us they would feel happy raising issues with executive managers.
- Pressure to care for patients in areas that was not appropriate and patients delayed in ambulances over the winter period had all had a negative impact on staff morale.
- Some staff felt there was limited autonomy at local level for decisions to be implemented and changes made. For example, some staff had voiced ideas but felt they had no freedom to take forward and they did not have ownership of suggested improvements.

Public and staff involvement and engagement

- Communication opportunities had been reduced within the department. Band 7 meetings in 2014 had taken place approximately every three months with band 6 meetings every 6 months. However, there had been a decision outside the department to remove these from the schedule in 2015.
- One member of staff stated that they had personal experience of raising concerns which they felt were patient safety issues. They then felt ostracised and blanked for a period of time by very senior management and stated that this only changed when "They became useful again." There was a repeated theme that staff felt that when they said "no" to a request they were seen to be obstructive rather than being supported for maintaining standards.
- Results from a patient survey showed that for 300 patients they scored 8.5 out of ten for involving patients in decisions about their care. Patients scored 9.9 out of ten for how well staff explained take home medications.

Innovation, improvement and sustainability

- Some Improvement and innovation had been facilitated at a local level. The development of the initial assessment bays had been staff led as a result of learning from processes developed in Nottingham
- There was an ED pharmacist pilot which was taking place between the 16th February and 23rd March. A dedicated pharmacist was in the department between 9am and 8:30 pm during the pilot.
- An automated pharmacy dispensary cupboard system was fitted during our inspection which was part of a three month trial. Staff training took place to ensure staff were competent with the units.
- There were plans within the staff room for building development and move of the ED and staff were aware of the intention to create a "village" which would also include a 24 hour GP service, dentist and pharmacy service.
- Senior staff had been involved in planning of the move of the minor's area and had attended some planning meetings. Information for staff was displayed on the notice board in the staff area.

Medical care (including older people's care)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Summary of findings

During this inspection we visited Mattishall Ward and the Henderson Unit (based off site) to follow up on whistleblowing concerns that had been raised, which had highlighted that the equipment and environment within Mattishall Ward was not fit for purpose and that staffing levels were not being maintained.

Mattishall ward had been opened in October 2014 in a clinical area used for clinical research studies. There were 19 beds which were used for patients who were due for discharge and up to four chairs also used for patients awaiting discharge. Audit data showed that the average length of stay for patients on the ward was less than one day. The ward was originally opened to create extra capacity.

The Henderson Unit had recently been opened in December 2014 as an action to improve hospital capacity. At the time of our inspection the unit had 26 beds available for patients requiring re-ablement following an acute hospital stay. This unit was run in conjunction with the County Council and was therapy led.

We also visited the Acute Medical Unit (AMU), Elsing Ward and Earsham Ward to follow up on a previous compliance action the trust had in place in relation to respecting and involving people who used the service.

Medical care (including older people's care)

Are medical care services safe?

Overall the areas we visited within the medical services directorate were meeting requirements.

The environment within Mattishall ward had been developed over previous months. However at the time of our inspection, improvements were still required. The layout of the ward was not appropriate being openly accessible to the clinical trials unit located directly next to it. Equipment was not fixed, a sluice was shared and staffing was not permanent. A plan was in place to completely renovate the area into a fully compliant and permanent ward area, however upon review, these plans were in their infancy and timescales had not yet been agreed.

Although there had been problems with the provision of service when the Henderson Unit first opened for example, closing on Christmas day due to lack of staff, this was acknowledged by staff to have been due to lack of initial planning and haste in opening. However the service had recently begun to run more efficiently and plans were in place to develop and improve the service.

Environment and equipment

- Appropriate risk assessments had been completed prior to and since the opening of Mattishall Ward and that issues raised were addressed. The risk assessments identified that the area was a 'sub optimal' environment for patients. The action plan shed that most environmental concerns had been mitigated such as the installing of the call bell system and portable oxygen.
- Plans were in place to completely renovate this ward so that a more appropriate ward environment could be achieved. When we reviewed these plans they were in their infancy and timescales for the start of this work had not yet been agreed. This meant we could not be assured that outstanding concerns in relation to this area (as described below) would be addressed in a timely way.
- There were four chairs that would be made available for patients awaiting discharge however during our visit these were not seen. There was no dedicated area for the chairs and if required they would be situated in one of the bays. This would mean patients ready for discharge would be sitting within the inpatient area which would impact on the ability to maintain privacy and dignity for either group.
- As the ward was partitioned outside a large 8 bed bay there was not adequate provision for patient's privacy on this ward. The ward was not suitably laid out and part of the ward was still used for clinical research. The ward was divided at one end by a large blue screen but staff from the ward and the research unit walked around the screen. A patient for clinical research accidentally walked onto the ward looking for the exit. Access for patients to the clinical research area was also through the ward passing patients bays
- Three patients on this ward also told us that they felt they could not undertake personal hygiene tasks privately in the sinks located next to their beds. This was because the bay curtains did not extend around the sinks.
- There was a lack of office space on the ward although there was a plan in place to address this.
- Storage and security was inadequate. A store room was unlocked and equipment was not stored securely. Inside the room were wheeled cupboards which were also unlocked and contained some medical equipment including urinary catheters, nebulisers and needles and syringes.
- The ward shared a sluice with the clinical research area. There was no piped oxygen to the ward but we saw that oxygen cylinders were available and that they were checked daily.
- In two bays there were no external light or windows. A patient we spoke with spoke highly of the care received on the ward but commented on the lack of natural light.

Assessing and responding to patient risk

- There were clear guidelines and admission criteria to Mattishall ward that reduced the risk of inappropriate patients being admitted to the ward. Staff on other wards were aware of the criteria for admission to the unit.
- However, we reviewed four sets of records and found that there was no explicit record of consideration of patients being medically fit for transfer to Mattishall ward. This meant that we could not be assured appropriate clinical decision making had been made based on patient risk.

Medical care (including older people's care)

Nursing staffing

- Staffing was 2 registered nurses and 2 care assistants during the day and 2 registered nurses and one care assistant overnight. Rotas we reviewed showed that these numbers were maintained. This meant that each registered nurse may be responsible for 11 patients.
- The ward was staffed predominantly by staff on two week placements from within the hospital though a senior member of nursing staff was seconded to work on the ward full time.
- However, as a decision had been recently taken to keep the ward open permanently, we were told that recruitment for permanent staff would now be undertaken.
- Nursing staff working in the area were the trusts own staff. Where they had been moved to work on the ward, their original ward was backfilled by agency staff. This meant there was no use of agency staff on Mattishall Ward.
- The nurse in charge of the shift at the time of our inspection was also coordinating the ward as well as being responsible for patients. Whilst the dependency of patients was low, there were a large number of discharges daily. We observed the nurse in charge to be organising discharges, answering the telephone and dealing with numerous questions and queries from staff and relatives. We were concerned that the nurse did not have adequate time to care for patients on the ward as well as coordinating it.

Medical Staffing

- We were concerned with the level of medical cover provided to Henderson Unit. Medical provision was provided by the Trust through a Consultant visiting the unit for two hours twice a week. We were concerned that this may not be sufficient to ensure timely review of patients with complex rehabilitation needs.

Consent and Mental Capacity

- On the Acute Medical Unit (AMU) we reviewed two patient records for patients who were living with dementia. Though the records stated that the patients were confused there was no indication that their capacity to make decisions about their treatment had been made. We spoke with a senior member of nursing staff who was unable to locate information or paperwork related to best interest's decisions.
- One patient who was living with dementia was due to have a medical intervention. We raised this matter immediately with senior staff who ensured the patient was properly assessed to determine their capacity to consent to treatment.
- We spoke with four staff about their responsibilities under the Mental Capacity Act. Two staff told us that capacity assessments were carried out by doctors. One member of staff gave us examples of the Mental Health Act. Staff were unclear of best interests' decisions. This meant staff were not clear of their responsibilities under the Mental Capacity Act 2005.
- When we asked to received training statistic on the numbers of staff who had received training on the mental capacity act, none could be provided to us. The mental capacity act training was included within the safeguarding adults training which meant that there was a risk staff were becoming confused in relation to their responsibilities.
- We were however provided with evidence which demonstrated that a bespoke mental capacity act training project was being rolled out within the Trust during March 2015.

Are medical care services caring?

We found in all areas that we visited that people's privacy and dignity was maintained. This was demonstrable on Elsing ward where a member of staff was walking with a patient ensuring dignity was maintained which was a notable improvement from our previous visit. All staff we spoke with in relation to this confirmed there had been lots of work undertaken in relation to improving this aspect of care. In total we spoke with 15 patients the majority of who reported positive experiences during their stay at this hospital and were complimentary about the staff.

In 2013 the trust was found to be non-compliant with requirements in ensuring people were respected and involved in their care and a compliance action was issued. The service had completed and implemented an action plan and significant improvements had been made during this inspection. We have therefore removed the compliance action and judged the trust to be meeting this requirement.

Compassionate care

- Throughout our inspection, we witnessed patients being treated with compassion, dignity and respect. Call

bells were answered promptly on most wards. Patients whom we spoke with told us that staff were caring, kind and compassionate. Our observations demonstrated that staff acted to protect people's dignity before it became compromised.

- Screens were pulled to ensure patients privacy when any care was being carried out.
- Staff spoke to people with care and compassion and they supported patient choice. For example, on Elsing Ward patients were encouraged to mobilise and sit where they chose.
- All patients were appropriately covered and clothed so as to protect their dignity.
- People commented that nursing and care staff were "kind" and "helpful". One person told us, that they felt the service provided to them was "first class" and another person stated they could not fault any aspect of the care provided to them.
- Patients were helped with meals in an unhurried way whilst staff actively engaged with them
- A member of staff was observed asking a patient what they liked to be called during their stay on the ward and then using that title when talking to them.
- We observed a patient being assisted to drink. The member of staff did so in an unhurried manner and maintained conversation with an obvious rapport.

Understanding and involvement of patients and those close to them

- Patients we spoke with on Mattishall ward were clear about the arrangements in place for them and why they had been transferred to the ward.
- The majority of other patients we spoke with told us that they felt involved in their care and knew what was happening day to day. They said that staff listened to them and explained their care. For example, one patient commented that "I have had all the information I need, I believe I have been well informed about my treatment"
- Staff discussed care with a patient's relatives- keeping them informed of the plan for their care and the next steps in treatment.

Are medical care services responsive?

It has been acknowledged that capacity was an issue for this trust and there were a high number of delayed transfers of care. It was however evident that the reasons for this was lack of community provision.

Plans were not yet well established in terms of ensuring a longer term improvement strategy for capacity and demand within the service. It was acknowledged that engagement from the wider health economy would be needed to take forward sustainable change.

Access and flow

- Capacity and demand remained a significant challenge for the trust: on average during January 2015 there were 57 delayed discharges of care within the trust on a daily basis and 55 during March.
- Information from a discharge monitoring report dated 18 March 2015 stated that 55 patients on that day were awaiting discharge. 23 of these patients had been waiting for between two and four days however eight patients had been waiting for more than 25 days to be discharged to an appropriate place of care.
- Discharge monitoring information provided to us demonstrated the reason for the majority of delayed transfers of care was the need for a community bed which was not available.
- In order to ensure patient safety and care was maintained, patients were reviewed on a daily basis by a multidisciplinary group of staff.
- The trust had taken action in order to improve patient flow with the introduction of Mattishall Ward and the Henderson Unit. However, impact from these initiatives had not yet been assessed and longer term plans could not be described to us.
- It had been recognised that the most challenging aspect of making improvements in this area was engagement with the local health economy and community providers. However, at the time of our inspection there was not a clear plan about how this engagement could be sought

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Summary of findings

At the time of our inspection the service was not meeting performance targets in relation to cancer waiting times. Patients who had not been seen within specified timescales were being monitored; we were not assured sufficient plans were in place to ensure sustainable performance improvement.

There was a serious incident in 2014 regarding VTE risk assessment and treatment in patients undergoing day surgery. The trust had put an action plan in place to address concerns arising from this incident. During this inspection we reviewed the improvements made and implementation of the action plan. We found that this had been actioned appropriately. This demonstrated learning and improvement had taken place.

Surgery

Are surgery services responsive?

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Access and flow

- The service was not meeting performance targets in relation to cancer waiting times. These related specifically to 31 day subsequent treatment surgery and 62 day GP referral to treatment targets. These targets had not been being met since April 2014.
- We had received an increase in intelligence from patients who had been unhappy with care and treatment provided to them in relation to their or their family member's cancer diagnoses.
- In February 2015 the trust only met 84.78% of its 31 day surgery target. The acceptable national target is 94%. It also significantly underperformed in meeting the 62 day GP referral target achieving only 73.88% against a national target of 85%.
- The clinical director responsible for this service explained that reasons for the shortfall in 62 day performance had been impacted by more complex surgery being performed within the head and neck and gynaecology divisions as well a patient back log within gynaecology.
- There had also been a 15% increase in urgent GP referrals in the preceding year impacting on the diagnostic provision within the trust in catering for the demand in patients being referred.
- Staff within the cancer service directorate confirmed that in order to ensure effective monitoring of patients who breached timescales root cause analysis were undertaken and regular PTL (patient tracking list) meetings were held to review all patients on the pathway.
- At the time of our inspection, there was no evidence to demonstrate that any patients had suffered an adverse clinical outcome due to breaching cancer waiting times. However, there was a significant risk of emotional impact for those people not receiving treatment within specified guidelines.
- We were told that a recovery plan was in place however when we asked to review an up to date version of this none could be provided to us. The last action plan that was supplied detailed that a review of actions had taken in place in November 2014.
- The majority of actions on this action plan had been marked as completed. However although an improvement in performance had been forecast this had yet to be reported. We were therefore not assured there are sufficient plans which are monitored to ensure that sustainable improvement in relation to cancer performance can be delivered.

Learning from complaints and concerns

- There had been a serious incident in 2014 regarding VTE risk assessment and treatment in patients undergoing day surgery. There was an action plan in place to address concerns arising from this incident.
- Patients were given information preoperatively about risk of VTE and how to reduce them. Patients were given further advice following the surgery and before discharge including in relation to mobility. The majority of VTE assessments were completed at the pre-operative admissions clinic and all pre assessments we reviewed had been completed. Audits showed that the vast majority of patients were given information regarding the risk of VTE pre and postoperatively.
- Training schedules showed that nursing staff completed eLearning in relation to VTE assessments and that most staff had completed it.
- The clinical guideline relating to VTE assessment and day surgery had been reviewed and amended. Staff in day surgery were aware of the change to practice that the guideline introduced. This included extended post-operative thrombo-prophylaxis for patients who had undergone varicose vein (VV) surgery under general anaesthesia.

Surgery

- Audit data showed a significant improvement in the consistency of completion of VTE risk assessments since October 2014 with 95% fully completed in January 2015.
- We reviewed 19 patient records for patients undergoing a range of surgical interventions including varicose vein surgery. All VTE assessments were accurately completed. Where risks were identified the appropriate prophylaxis was prescribed in line with the hospital clinical guidance including the use of post-operative low molecular weight heparin (LMWH).
- We spoke with two consultants. They were aware of the clinical guidance in place in the department and were clear about patients who should be prescribed appropriate prophylaxis.
- In theatres, two patients' risk of VTE was discussed between the consultant surgeon and anaesthetist team prior to surgery and they ensured appropriate treatment had been prescribed. This included the use of LMWH following surgery and compression hosiery.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

1. The trust should ensure that there is a clear strategic escalation plan in place for access and flow of patients through the emergency department and that there is a consistent management approach in response to high demand pressures.
2. The trust should ensure that all staff receives training on the mental capacity act and that this is continuously monitored.
3. The trust should consider how it can demonstrate clinical decision making in those patients records who are admitted to Mattishall Ward.
4. The trust should consider how it can demonstrate and provide assurance that improvement to cancer services and demand for services will be sustainable.