

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

## Inspection report

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

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

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

## Ratings

### Overall rating for this trust

Inadequate 

Are services safe?

Inadequate 

Are services effective?

Inadequate 

Are services caring?

Requires improvement 

Are services responsive?

Requires improvement 

Are services well-led?

Inadequate 

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

# Summary of findings

## Background to the trust

The Queen Elizabeth Hospital King's Lynn is an established 488 bed general hospital on the outskirts of King's Lynn, Norfolk. It provides healthcare services to West and North Norfolk in addition to parts of Breckland, Cambridgeshire and South Lincolnshire. The population of this area is approximately 331,000 people. The population profile includes a high proportion of older residents; however, new housing developments in recent years have seen large population growth of principally young families.

The trust provides a comprehensive range of specialist, acute, obstetrics and community-based services. The trust works with neighbouring hospitals for the provision of tertiary services and is part of regional partnership and network models of care, such as the trauma network.

Some specialist services and clinics were provided in community facilities, such as the North Cambridgeshire hospital in Wisbech.

Between March 2018 and February 2019 there were:

- 79,685 inpatient admissions
- 315,519 outpatient attendances
- 66,333 accident and emergency attendances

The trust achieved Foundation Trust status in 2011.

The trust is part of the Norfolk and Waveney Sustainability and Transformation Plan (STP).

The trust is commissioned by clinical commissioning groups from three counties. The lead commissioner is West Norfolk Clinical Commissioning Group.

Previously CQC carried out a comprehensive inspection at the Queen Elizabeth Hospital King's Lynn NHS Foundation trust between the 4 April and 24 June 2018. We found significant concerns and risks to patients within the medicine service, urgent and emergency service and the maternity service which we raised with the trust at the time of inspection. Following the core service inspection, we undertook enforcement in respect of the maternity and midwifery service to enable the improvement of safety within the service. We issued a warning notice under Section 29A of the Health and Social Care Act 2008 on 17 May 2018. We then issued on the 19 July 2018 an urgent notice of decision to impose conditions on the trust's registration as a service provider, under Section 31 of the Health and Social Care Act, 2008. Based on this inspection, the Chief Inspector of Hospitals recommended that the trust be placed into special measures.

We undertook an unannounced focused inspection of the maternity service in December 2018 to follow up specifically on the compliance with the ten points of concern within the Section 29A warning notice. We found several areas of improvement. Action had been taken, and the trust was part compliant in terms of the Section 29A warning notice, however there were aspects that required further improvement. Following this inspection, we issued a requirement notice under Regulation 17 Health and Social Care Act (RA) Regulations 2014 Good governance.

We inspected the trust between the 5 March 2019 and 24 April 2019. The core service inspection took place between the 5 and 7 March 2019 and covered seven core services and one additional service: urgent and emergency care, medicine, surgery, children and young people, maternity, end of life care, outpatients and gynaecology. A well led inspection at provider level took place between the 9 and 11 April 2019. On the same dates we also inspected the additional service of diagnostic imaging due to escalating concerns. We also undertook a further unannounced inspection on 24 April 2019.

# Summary of findings

## Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as **Inadequate**   

## What this trust does

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust provides a comprehensive range of specialist, acute, obstetrics and community-based services. Services are provided at The Queen Elizabeth Hospital in King's Lynn and some specialist services and clinics are provided in community facilities, such as North Cambridgeshire hospital in Wisbech and St Georges Medical Centre in Littleport.

Services provided at The Queen Elizabeth Hospital include urgent and emergency care, medical and surgical care, critical care, maternity and gynaecology, neonatal and paediatric care, end of life care, outpatient services and diagnostic imaging services.

## Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

## What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse. The trust was placed in special measures in September 2018 following significant concerns found in several services and was told it must take action to improve.

We inspected the trust between the 5 March 2019 and 24 April 2019 to review progress. The core service inspection took place between the 5 and 7 March 2019 and covered seven core services and one additional service: urgent and emergency care, medicine, surgery, children and young people, maternity, end of life care, outpatients and gynaecology.

A well led inspection at provider level took place between the 9 and 11 April 2019. On the same dates we also inspected the additional service of diagnostic imaging due to escalating concerns. We also undertook a further unannounced inspection on 24 April 2019.

## What we found

### Overall trust

Our rating of the trust stayed the same. We rated it as inadequate because:

Safe, effective and well led were rated as inadequate, responsive and caring were rated as requires improvement. The ratings for effective and caring had gone down. Ratings for safe responsive and well led had remained the same.

# Summary of findings

Our inspection of the core services covered The Queen Elizabeth Hospital King's Lynn only. Our decisions on overall ratings take into account, for example, the relative size of services and we use our professional judgement to reach a fair and balanced rating.

On the basis of this inspection, the Chief Inspector of Hospitals has recommended that the trust remain in special measures.

## The Queen Elizabeth Hospital

### Urgent and emergency care

- The rating for Urgent and emergency care remained inadequate overall. The ratings for safe, responsive, and well-led remained the same, safe and well-led were rated inadequate and responsive was rated requires improvement. The rating for caring went down from good to requires improvement and the rating for effective went down from requires improvement to inadequate. The service did not always ensure that staff identified, monitored and responded appropriately to changing risks to people who used services, including deteriorating health and behaviour that challenges. There were concerns about staffing, incident investigation processes, the environment for patients with mental health concerns and documentation. The privacy and dignity of patients was not always maintained, and staff members did not always display an understanding and non-judgemental attitude when talking about patients and relatives. People could not access care and treatment in a timely way. Leaders either had not identified or had not acted to address some of the concerns that we identified during our current or last inspection. Leaders did not receive sufficient support or time to undertake their leadership roles effectively and maintain sufficient oversight over the department.

### Medical care (including older people's care)

- The rating for Medical care remained inadequate overall. Safe and well led remained inadequate, effective had gone down from requires improvement to inadequate. Caring and responsive remained rated as requires improvement. The service did not manage patient safety incidents well. Staff recognised incidents, but the quality of investigations was not always robust. The service did not control infection risk well. The service did not ensure that premises was safe. Staff did not keep appropriate records of patients' care and treatment. Staff did not understand how to protect patients from abuse. The service provided mandatory training in key skills to all staff but not all staff had completed it, particularly medical staff. The service did not have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. Staff did not always have access to up-to-date, accurate and comprehensive information on patients' care and treatment. Staff did not understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Staff did not always care for patients with compassion. Staff did not always involve patients and those close to them in decisions about their care and treatment. The service did not take account of patients' individual needs. The trust did not have managers at all levels with the right skills and abilities to run a service. There was a significant lack of improvement since our last inspection and lack of capacity in divisional leadership to effect sustainable change. The trust did not have effective systems for identifying risks. We identified risks that the service had not addressed, and the service had failed to act on known past risks. However, the service planned for emergencies and staff understood their roles if one should happen. Staff of different kinds worked together as a team to benefit patients.

### Surgery

- Surgery services remained rated as requires improvement. Safe and responsive remained as requires improvement, effective had improved from requires improvement to good and caring and well led remained good. Staff did not always complete mandatory training in line with the trust's target. Medical staff did not always complete training to recognise and safeguard patients from abuse. Staff within main theatres, did not always fully complete the debrief section of the World Health Organisation (WHO) and five steps to safer surgery checklist. The service did not always

# Summary of findings

have enough nursing staff to keep people safe from avoidable harm and to provide the right care and treatment. Patients did not always receive their medication at the right time. People could not always access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with good practice. The timeliness of complaint responses did not meet local policy targets. Main theatres did not always complete adequate assurance audits. However, the service controlled infection risk well, kept detailed records of patients' care and managed patient safety incidents well. The service provided care and treatment based on national guidance and managers monitored the effectiveness of care and treatment. Staff of different kinds worked together as a team to benefit patients. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff cared for patients with compassion, provided emotional support to patients and involved patients and those close to them in decisions about their care and treatment. The trust planned and provided services in a way that met the needs of local people and took account of patients' individual needs. Managers had the right skills and abilities and promoted a positive culture. Surgery had a vision for what it wanted to achieve and workable plans to turn it into action. The service managed risks effectively. The service engaged well with patients, staff, the public and local organisations.

## Maternity

- The rating for maternity had improved to requires improvement overall. Safe and well led had improved from inadequate to requires improvement, responsive had improved from inadequate to good, effective had improved from requires improvement to good and caring remained good. Some mandatory training and safeguarding training rates did not meet trust targets. The department had midwifery vacancies which meant that some clinical areas were short staffed at times. Staff were not always aware of a procedure to ensure that agency midwives had received suitable training, were competent and that swipe card access to the unit was monitored. The number of midwives and doctors whom had received training to be competent in identifying small for gestational age babies was low. Several of the senior leadership roles were locum or interim posts. There was no formal vision or strategy in place. There was a lack of effective communication to staff about changes taking place or planned in the unit. Whilst there appeared to be a good culture in the unit, staff felt uncertain about their future direction due to changes in leaders. However, the service controlled infection risks well and had suitable premises and equipment. Staff completed appropriate records and risk assessments. The service managed medicines and safety incidents well. The service had taken action to update policies in line with national guidance however this remained ongoing at the time of inspection. The service carried out audits and evaluations to ensure the compliance and the effectiveness of care provision. Staff cared for women and their families with compassion, provided emotional support and involved women and those close to them in decisions about their care and treatment. The service planned and provided services to meet the needs and wishes of its service users and took account of peoples' individual needs. Governance processes were improving.

## Gynaecology

- Gynaecology was rated as requires improvement overall. Safe, responsive and well led were rated as requires improvement. Effective and caring were rated as good. Mandatory training compliance rates were poor for both nursing and medical staff. Not all nurses had the appropriate competency based skills. There was a high use of locum medical staff, and not all had relevant skills to undertake ultrasound scanning. The service did not routinely audit the effectiveness of care and treatment and use the findings to improve. Timeliness of complaints needed to improve. Concerns raised by staff were not always acted upon in a timely manner. Staff felt there was limited action taken and were not empowered to improve the quality of care. However, there were systems in place to manage infection prevention and control and medicine management. Staff worked together to benefit patients and cared for patients with compassion. The service took account of individual patient needs.

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## Services for children and young people

- The rating of children and young people's services remained good. Safe, effective, caring and responsive remained good, well led had gone down from good to requires improvement. Nursing staff mandatory training compliance was close to the trust target. Staff had training on how to recognise and report abuse and knew how to protect patients. Staff kept detailed records of patients' care and treatment which was based on national guidance, completed and updated risk assessments for each patient and followed best practice when prescribing, giving, recording and storing medicines. The service had enough nursing and medical staff with the right qualifications, skills, training and experience. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005 and cared for patients with compassion; involving them in decisions about their care where appropriate. Managers appraised staff's work and staff of different specialities worked together as a team. Waiting times from referral to treatment were in line with good practice. Managers at all levels in the service had the right skills and abilities to run a service and promoted a positive culture that supported and valued staff. The service had effective systems for identifying risks and engaged with patients and staff to plan and manage appropriate services. However, mandatory training compliance for medical staff did not meet trust target for any of the modules. Safeguarding children level three training compliance for nursing and medical staff did not meet trust target and the service did not have enough consultants to meet with royal college of paediatric and child health (RCPCH) guidance. Governance structures were not embedded, not robust and did not give enough consideration to children and young people's services or monitor the progress of the service strategy which staff were unaware of.

## End of life care

- The rating for end of life care went down to inadequate overall. Safety remained requires improvement. Effective remained inadequate, responsive went down from good to inadequate and well led went down from requires improvement to inadequate. Caring remained good. Use of the individualised plan of care (IPOC) had not been embedded throughout the trust which meant patients did not always receive person-centred care that met their needs. Not all records reviewed contained documentation about ceilings of treatment. Palliative consultant staffing was not in line national guidance and senior leadership did not take ownership of end of life care or have sufficient oversight of performance within the service. We were not assured that risks were escalated appropriately. There had been a failure to address previous concerns. There remained a lack of ownership and oversight for the service, end of life care was not seen as a priority. There was no stable leadership team to support and promote end of life care. Data provided to demonstrate key performance metrics was inaccurate. There was no effective strategy in place for end of life care. There had been no improvement in the development or engagement of the strategy.

## Outpatients

- The rating for outpatients remained requires improvement. Safe had improved from requires improvement to good and caring remained good. Responsive and well led remained requires improvement, effective is not rated. Some outpatient areas did not meet the needs of the service and impacted on staff ability to protect patients' privacy and dignity. Outpatient areas did not routinely audit the effectiveness of care and treatment and use the findings to improve them. Non-admitted referral to treatment pathway rates were below the trust's operational standard and the England average. The trust did not routinely collect data on late starting clinics or patient waits in outpatients. The outpatient's department had no local vision. We were not assured that local risk and performance was monitored appropriately. The trust did not have processes in place to engage with patients, the general public and local organisations. Processes and systems of accountability within clinical business units were not always effective. However, the service managed patient safety incidents and medicines well and kept appropriate records of patients' care and treatment. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. The service made sure staff were competent for their roles. Staff of different kinds worked together



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as a team to benefit patients. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Staff cared for patients with compassion. The service treated concerns and complaints seriously. The service had managers at all levels with the right skills and abilities to run a service and they promoted a positive culture.

## Diagnostic imaging

- Diagnostic Imaging was rated as inadequate overall. Safe, and well led were rated as inadequate. Responsive was rated as requires improvement. Caring was rated as good. Effective was not rated. Staff did not recognise incidents or report them. Staff were unclear about their understanding and responsibility when administering contrast media. The service had not ensured that policies and procedures were in place across the diagnostic imaging department. Learning from incidents and complaints were not shared effectively with staff. There was not an effective management team in place, staff morale was low, and staff felt there was a disconnect between themselves and managers. The service did not have effective systems in place for identifying, escalating and acting to eliminate or reduce risk. However, staff worked together to benefit patients and cared for patients with compassion. The service took account of individual patient needs.

## Are services safe?

Our rating of safe stayed the same. We rated it as inadequate because:

- Urgent and emergency services remained rated as inadequate for safe. The service did not always ensure that staff identified, monitored and responded appropriately to changing risks to people who used services, including deteriorating health and behaviour that challenges. The numbers and skill mix of nursing staff were not always suitable for the needs of the emergency department and medical staffing establishment levels were not in line with national guidance. The arrangements for investigating incidents and for implementing changes to practice as a result of learning from serious incidents and deaths were not always robust. Duty of candour was not being consistently carried out when required. Staff did not always ensure that information relating to a patients' care and treatment was appropriately recorded. Records systems did not support staff to deliver safe care and treatment. The design and use of facilities and premises in the emergency department did not always keep patients with mental health concerns safe. However, medicines were managed and administered appropriately.
- Medical care remained rated as inadequate for safe. The service did not manage patient safety incidents well and the quality of investigations was not always robust. Staff were not trained to complete root cause analysis or investigate complex issues. The service did not control infection risk well. We saw a number of examples of poor infection control practice in ward areas. There were control of substances hazardous to health (COSHH) breaches and issues with hot water in unsecured sluice rooms. Staff did not keep appropriate records of patients' care and treatment. Records were not clear, did not contain a plan of care, there were frequent omissions in records and they were not secure. Staff gave inconsistent responses in how to raise safeguarding concerns and failed to act on a safeguarding issue. The service provided mandatory training in key skills to all staff but not all staff, particularly medical staff had completed it. There remained a very high vacancy rate for nursing staff with frequent use of agency. There was a reliance on locum doctors in a number of areas. However; the service planned for emergencies and staff understood their roles if one should happen. There had been improvements in nurse shift fill rates.
- Our rating of surgery remained requires improvement for safety. Staff did not always complete mandatory training in line with the trust's target. Medical staff did not always complete training to recognise and safeguard patients from abuse. Theatre staff did not always fully complete the debrief section of the World Health Organisation (WHO) and five steps to safer surgery checklist. The service did not always have enough nursing staff to keep people safe from avoidable harm and to provide the right care and treatment. Patients did not always receive their medication at the right time. However, the service controlled infection risk well and had suitable premises and equipment. Staff kept detailed records of patients' care and treatment and managed patient safety incidents well.

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- Our rating of maternity had improved to requires improvement for safety. Some mandatory training rates failed to meet trust targets and safeguarding training rates were considerably lower than target. The department had midwifery vacancies which meant that some clinical areas were short staffed at times. Staff were not always aware of a procedure to ensure that agency midwives had received suitable training, were competent to care for women and their babies and that swipe card access to the unit was monitored. The 100% compliance rate for training and competence for all appropriate staff reviewing, interpreting and classifying Cardiotocography (CTG) traces, outlined within the Section 31 urgent notice of conditions, served on 19 July 2018, had not been sustained. However, the service controlled infection risks well and had suitable premises and equipment. Staff completed appropriate records and risk assessments for all women and babies being cared for. The service prescribed, administered, recorded and stored medicines well. The service managed safety incidents well.
- Gynaecology was rated at requires improvement for safe. Mandatory training compliance rates did not meet trust target. Not all areas controlled infection well. The early pregnancy antenatal unit did not have the appropriate facilities to provide safe care and treatment. Not all nursing staff had Gynaecology competencies in place and there was concern around ultrasound scanning competencies of locum medical staff. Staffing in the early pregnancy unit was limited and did not always meet the appropriate levels to ensure patient safety
- Children's and young people's (CYP) services remained rated good for safe. Nursing staff had completed mandatory training and had a good understanding of safeguarding. Staff kept equipment and the premises clean and used infection prevention and control. There were enough nursing and junior grade medical staff to care for patients and who kept clear records of care and managed medicines appropriately. However, nursing and medical staff had not completed safeguarding training and medical staff did not complete mandatory training in line with trust target. The service did not have enough consultants in order that they could meet with royal college of paediatric and child health (RCPCH) guidance, this was mitigated by consultants working additional hours. There was not always representation of the CYP service at mortality review meetings.
- The rating for end of life care remained requires improvement for safe. The service provided mandatory training, however trust targets for completion were not always met. Patient records were not always clear and were often left unsecure. The use of the individualised plan of care (IPOC) had not improved and ceilings of care were not always documented. Palliative consultant staffing was not in line with national guidance. We were not assured that all patient safety incidents were being captured and managed appropriately. However, staff understood how to protect patients from abuse. The service controlled infection risk well and had suitable premises and equipment. The service had enough nursing staff which was in line with national guidance.
- The rating for outpatients remained good for safety. The service managed patient safety incidents, controlled infection risk and managed medicines well. Staff kept appropriate records of patients' care and treatment. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. However, managers reported that at times face to face training courses were cancelled which impacted staff training compliance. Some outpatient areas did not meet the needs of the service, for example the diabetic clinic consulting room.
- The rating for diagnostic imaging went down to inadequate for safe. The service did not manage safety incidents well, staff did not recognise incidents or report them. Staff did not always follow best practice to control infection risk and mandatory training rates were below the trust target. Staff were unclear about their responsibilities when administering contrast media and how findings that required further investigation were escalated to ensure that patients received timely and appropriate care. The service did not have enough staff with the right qualifications, skills, training and experience in all areas to provide the right care and treatment. However, staff knew how to protect patients from abuse, planned for emergencies and staff understood their roles if an emergency should happen.



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## Are services effective?

Our rating of effective went down. We rated it as inadequate because:

- Urgent and emergency services rating had gone down from requires improvement to inadequate for effectiveness. We observed examples of care which demonstrated that national guidance was not always being followed in the department. There remained concerns about a significant number of out of date guidelines and policies. Audit activity to support and monitor the implementation of national guidance was limited due to staffing shortages. Performance in national audits was mixed. There was limited evidence of learning and action when national audit results were in the lower UK quartile. Patients with specific nutrition and hydration needs and patients' pain levels were not always identified and monitored appropriately. There was not always evidence of positive multidisciplinary working in the urgent and emergency service. Staff did not always understand the relevant consent and decision-making requirements of the Mental Capacity Act 2005. However, the department had improved the oversight in relation to the completion of competencies.
- The rating for medical care went down to inadequate for effective. The service did not provide care and treatment based on national guidance. The service did not monitor the effectiveness of care and treatment and used the findings to improve them. We saw examples of poor audit results such as NEWS2 audit which were not repeated to measure improvement. Records audits showed consistently poor results without significant improvement. Staff did not always have access to up-to-date, accurate and comprehensive information on patients' care and treatment. Staff gave inconsistent responses when asked about the Mental Capacity Act 2005 (MCA). We found instances where the MCA was not properly considered. However, staff of different kinds worked together as a team to benefit patients. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service. The service performed particularly well in national stroke audit.
- The rating for surgery had improved to good for effective. The service provided care and treatment based on national guidance and evidence of its effectiveness. Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain. Managers monitored the effectiveness of care and treatment although there was limited evidence that they use audit to improve service. The service made sure staff were competent for their roles. Staff of different kinds worked together as a team to benefit patients. However, staff did not always complete training in relation to Mental Capacity Act and deprivation of liberty safeguards (DoLS).
- The rating for maternity had improved to good for effective. The majority of policies and procedures had been updated in line with current national guidance to ensure the service provided care and treatment based upon best practice. The service carried out audits and evaluations to ensure both the compliance and the effectiveness of care provision and to benchmark their performance and highlight areas for improvement. Staff gave women and babies sufficient nutrition and hydration to meet their needs and wishes. Staff managed pain well. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support women experiencing mental ill health and implemented individualised care plans when needed. However, the number of midwives and doctors whom had received training to be competent in identifying small for gestational age babies was low. There were 32 guidelines that still required reviewing and updating despite this being one of the 10 conditions outlined in the Section 31 notice served on 19 July 2018.
- Gynaecology was rated as good for effective. Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff assessed and monitored patients regularly to see if they were in pain and provided adequate nutrition and hydration to meet patients' needs. Staff worked together to benefit others and there was seven day medical provision in place, including out of hours, from an obstetrics and gynaecology consultant. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the

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Mental Capacity Act 2005 and knew how to support patients that were experiencing mental ill health and those that lacked capacity to consent. However, the service did not routinely audit the effectiveness of care and treatment and use the findings to improve them. Mental Capacity Act training for medical staff was poor, with a compliance rate of 43%.

- The rating for children's and young people's (CYP) services remained good for effective. The service provided care and treatment based on national guidance, staff gave patients enough food and drink to meet their needs and monitored patients regularly to see if they were in pain. Managers monitored the effectiveness of care and made sure staff were competent for their roles. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Staff of different specialities worked together as a team to benefit patients. However, one member of nursing staff was heard to use discriminatory language when speaking about a patient with known mental health issues.
- The rating for end of life care remained inadequate for effective. The individualised plan of care (IPOC) was not effectively implemented or consistently used across the organisation and was therefore not embedded in practice. This was raised as an issue at our last inspection in 2018. Further improvement was required in relation to completion of do not attempt cardio pulmonary resuscitation (DNACPR) forms to ensure the safety of patients. Mandatory training in the Mental Capacity Act was below trust target. We remained concerned that mental capacity assessments were not always completed for people who had DNACPR forms in place. Local audit was not used effectively to improve practice. Nursing staff did not receive sufficient formal supervision and instead arranged their own informal supervision. However, staff assessed and monitored patients regularly to see if they were in pain. Multi-disciplinary members of staff worked together as a team.
- We do not currently rate the effectiveness of outpatient services. The service provided care and treatment based on national guidance. Managers checked to make sure staff followed guidance. The service made sure staff were competent for their roles. Multidisciplinary staff worked together as a team to benefit patients. Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. However, outpatient areas did not routinely audit the effectiveness of care and treatment and use the findings to improve. This had not improved since our previous inspection in 2018.
- We do not currently rate the effectiveness of diagnostic imaging services. The service had not ensured that policies and procedures were in place across the diagnostic imaging department. The service did not ensure staff were competent in their roles, not all staff had received an appraisal and staff routinely worked outside the patient group direction (PGD). The system to staff the out of hours service was not effective or sustainable and some members of staff reported they felt bullied by doctors in the emergency department out of hours. However, staff knew how to support patients experiencing mental ill health and those who lacked capacity. The service had obtained ISAS accreditation in 2012.

## Are services caring?

Our rating of caring went down. We rated it as requires improvement because:

- The rating for urgent and emergency services had gone down to requires improvement for caring. The privacy and dignity of patients was not always maintained. Staff members did not always display an understanding and non-judgemental attitude when talking about patients and relatives. There was mixed feedback from patients about the care provided by staff.
- The rating for the medical care service remained requires improvement for caring. Staff did not always care for patients with compassion. We saw numerous instances of neutral care interactions and occasions where staff

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appeared indifferent to their caring role. Staff did not always involve patients and those close to them in decisions about their care and treatment. Several patients and relatives told us they had to ask multiple times for information relating to their care. We observed two relatives who had not been informed of changes in care of their family member. However, we saw some examples of individual care and support such as by a care assistant on Necton Ward.

- The rating for surgery services remained good for caring. Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Staff provided emotional support to patients to minimise their distress. Staff involved patients and those close to them in decisions about their care and treatment.
- The rating for maternity services remained good for caring. Staff cared for women and their families with compassion. Feedback and observations confirmed that staff treated patients well, with kindness and compassion. Staff provided emotional support to women and their partners to minimise their distress. Staff involved women and those close to them in decisions about their care and treatment. We observed staff interacting positively with women and those close to them.
- Gynaecology was rated good for caring. Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness and staff provided emotional support to patients to minimise their distress. Patients were involved in decisions about their care and treatment.
- The rating for children's and young people's services remained good for caring. Staff cared for patients with compassion and feedback from patients confirmed that staff treated them well and with kindness. Staff provided emotional support to patients to minimise their distress and involved patients and those close to them in decisions about their care and treatment.
- The rating for end of life care remained good for caring. Staff cared for patients with compassion. Feedback from patients and their families confirmed that staff treated them well and with kindness. Staff provided emotional support to patients to minimise their distress. Staff involved patients and those close to them in discussions about their care and treatment.
- The rating for outpatients remained good for caring. Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Staff involved patients and those close to them in decisions about their care and treatment. Staff provided emotional support to patients to minimise their distress. However, the environment within certain areas of the outpatient service did not always ensure that patient's privacy and dignity were protected. In the diabetic clinic patients were seen in a room that also acted as a storage cupboard meaning staff accessed the room to collect supplies.
- The rating for diagnostic imaging remained good for caring. Staff cared for patients with compassion. Patients told us that they were treated well and with kindness. Staff involved patients and those close to them in decisions about their care and treatment and provided support to patients to minimise their distress.

## Are services responsive?

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

- Urgent and emergency services remained rated as requires improvement for responsive. People could not access care and treatment in a timely way. The issues impacting upon flow had not been addressed since the time of our last inspection. The department had not always ensured that systems and processes were in place to meet patient's individual needs. There had been an increase in the number of complaints and there were delays in responding to complaints.
- The medical care services remained rated as requires improvement for responsive. The service did not take account of patients' individual needs. We saw and heard examples of the service failing to meet the needs of patients. The

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service was slow to respond to complaints, even those requiring a simple explanation. However, the trust planned and provided services in a way that met the needs of local people. People could access the service when they needed it. Waiting times for treatment and arrangements to admit, treat and discharge patients were in line with good practice.

- Surgery services remained rated as requires improvement for responsive. People could not always access the service when they needed it. Waiting times from referral to treatment performance had deteriorated since our last inspection in 2018 in respect of plastic surgery, general surgery and orthopaedic surgery. The timeliness of complaint responses did not meet local policy targets. However, the service took account of patients' individual needs and the trust planned and provided services in a way that met the needs of local people.
- The rating for maternity services had improved to good for responsive. The service planned and provided services to meet the needs and wishes of its service users. Women could access the service when they needed and wanted to. The service took account of peoples' individual needs. The service worked with external agencies to provide tailored care to women such as for pregnant teenagers. The service treated complaints and concerns seriously, investigated them and shared the lessons learnt with staff and, if appropriate, made changes to practice to improve care.
- Gynaecology was rated at requires improvement for responsive. People could not always access the service when they needed it. The trust's referral to treatment time (RTT) for incomplete pathways has been worse than the England overall performance which meant patients waiting longer for appointments when referred from their general practitioner (GP). We found a significant number of patients that were awaiting results and a follow up appointment after clinical procedure or investigations. This had not been escalated internally and the trust were unaware of the backlog. Following us raising the concern the trust took appropriate action to address this and see all affected patients by the end of April 2019. The timeliness of complaint responses did not meet local policy targets. However, services were planned and provided with clear pathways for elective and emergency admissions. Staff supported patients living with dementia and those with learning disabilities.
- The rating for children's and young people's (CYP) services remained good for responsive. The trust planned and provided services in a way that met the needs of local people and took account of patients' individual needs. People could access the service when they needed it and waiting times from referral to treatment were in line with good practice. The service treated concerns and complaints seriously, investigated them and learned lessons from the results.
- The rating for end of life care went down to inadequate for responsive. Data provided in relation to key performance metrics, such as whether patients achieved their preferred place of death, was inaccurate with errors in calculations and narrative. The trust had failed to continue to monitor the number of patient referrals to the palliative care team which meant a reduction in oversight from our previous inspection in 2018. The trust was unable to provide data that waiting times from referral to treatment were in line with good practice. This meant we were not assured patients had access to the specialist palliative care team when they needed it. We were not assured that the trust met peoples' needs through the way services were organised and delivered or that the service was meeting the or identifying unmet needs of patients and using that information to improve and develop services. However, the service took account of patients' individual needs once identified as end of life and treated complaints and concerns seriously.
- Our rating of outpatients remained requires improvement for responsive. The trust's referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance. There were 6374 patients on the backlog list awaiting a follow up appointment, with the longest overdue waits within urology, gastroenterology and ophthalmology. Between August 2018 and February 2019, a total of 866 clinics were cancelled and 62% of these had a notification of six weeks or under. The trust did not routinely collect data on late starting clinics or patient waits in outpatients. Car parking facilities did not always meet demand. However, the trust was performing better than the

# Summary of findings

96% operational standard and similar to the England average for patients waiting less than 31 days before receiving their first treatment following a diagnosis of cancer. The trust planned and provided services in a way that reflected the needs of local people. The service took account of patients' individual needs. The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

The rating for diagnostic imaging remained requires improvement for responsive. The service did not share learning from complaints with staff effectively. The service did not have a process in place to effectively monitor nonattendance rates and information around report turnaround times did not provide assurance that data was used to improve the service to patients. Weekend and evening appointments were available but at times had to be cancelled due to staffing capacity. However, the service took account of patient's individual needs and provided some flexibility in appointment times and continuity of care.

## Are services well-led?

Our rating of well-led stayed the same. We rated it as inadequate because:

- Urgent and emergency services remained rated as inadequate for well-led. Leaders either had not identified or had not taken action to address some of the concerns that we identified during our current or last inspection. Not all risks identified during our current inspection or our last inspection had been included on the risk register. Leaders did not receive sufficient support or time to undertake their leadership roles effectively and maintain sufficient oversight over the department. There was no separate formal strategy for urgent and emergency services. Staff felt able to raise concerns but did not feel that these were always listened to or addressed. However, the new matron had acted to increase the level of engagement of staff in the department and there was evidence of innovation in the ambulatory emergency care unit.
- The rating for the medical care service remained inadequate for well led. The trust did not have managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. There was a significant lack of improvement since our last inspection and lack of capacity in divisional leadership to effect sustainable change. The service did not have a coherent vision or strategy. Staff did not identify with the division's priorities. They did however relate to the trust values and vision. The culture was mixed in the division. Some staff told us of improvements however, we had received whistle blowing information prior to the inspection from concerned staff. We were aware of examples of poor communication in the service that impacted staff morale. The trust did not have effective systems for identifying risks. Some risks on the risk register had been on the register for up to eight years. We identified risks that the service had not addressed, and the service had failed to act on known past risks. The trust did not collect or use information well to drive improvements. There was insufficient evidence to demonstrate that the trust was committed to improving services by learning. The service had failed to learn from previous concerns raised by the coroner under regulation 28.
- The rating for surgery services improved to good for well-led. Managers at all levels in the division had the right skills and abilities to run a service and were sighted on improving the quality and safety of care. The service had a vision for what it wanted to achieve and workable plans to turn it into action. Managers across the service promoted a positive culture that supported and valued staff. The service had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively. Surgery was committed to improving services by learning from when things went well, promoting training, research and innovation. However, main theatres did not always complete adequate assurance audits in surgical safety. Managers had not detected or acted upon issues related to records of the debrief step of the World Health Organisation (WHO) and five steps to safer surgery checklist.



# Summary of findings

- The rating for maternity services had improved to requires improvement for well-led. Improvements remained fragile with clarity of leadership, systems and process not yet stabilised or embedded. Several of the senior leadership roles were still locum or interim positions. Governance processes needed to continue to improve. Changes had taken place but were yet to be fully achieved and sustained. Oversight of previous actions and improvements was not robust to ensure improvements were sustained. Risk and quality performance processes were not fully embedded or effective to ensure improvements were ongoing, sustained and driven forward. The service had failed to ensure compliance in relation to previous enforcement action. There remained no formal vision or strategy in place and the risk management strategy remained under review. There was a lack of effective communication to staff about changes taking place or planned in the unit. Whilst it appeared that the improved culture had continued, staff felt uncertain about their future direction due to differing leaders. Whilst some staff felt that engagement with them was improving, it appeared to fall short in several areas. However, the service collected, analysed, managed and used information well to support all of its activities and was committed to improving services by learning from when things went well and when they went wrong, promoting training, audit and evaluation.
- Gynaecology was rated as requires improvement for well led. As a standalone service gynaecology lacked clarity and definition. Whilst there was overlap of specialist nurses and medical staff with the maternity service a specific focus on gynaecology was inconsistent. Several of the senior leadership roles were locum or interim posts. Leaders of the service did not always act on concerns raised in a timely manner and staff did not feel empowered to improve the quality of care. The arrangement for governance and performance management were not fully clear and did not operate effectively. Managers had failed to escalate the backlog of patients who required a follow up appointment or medical review. National and local audit was not utilised effectively to improve services. Systems in place to identify and manage risk were not monitored effectively. There was no vision for the service and staff and patients were not actively engaged with.
- The rating for children's and young people's (CYP) service went down to requires improvement for well led. The CYP strategy was not embedded and the service did not monitor progress against delivering the strategy. Governance structures were not embedded, not robust and did not give enough consideration to children and young people's services. There was no representation of CYP services at the mental health governance committee meetings or the quality and safety committee meetings. However, managers at all levels in the service had the right skills and abilities to run a service and promoted a positive culture that supported and valued staff. The service had effective systems for identifying risks and coping with both the expected and unexpected. The service engaged with patients, staff, the public and had plans to improve and sustain the service.
- The rating for end of life care went down to inadequate for well-led. There was a lack of ownership of end of life care from senior leaders. Staff we spoke to during our inspection were not aware of who the lead was for end of life care. The end of life care strategy did not contain workable plans to turn it into action. Staff we spoke to, including senior staff, could not describe what the end of life care strategy was. Part of the strategy included that staff would be trained in using the individualised plan of care (IPOC) which had not been embedded within the trust. Staff felt end of life care was not considered to be a priority within the trust. There was a lack of oversight in ensuring that the end of life strategy was implemented, including the IPOC. We were not assured that issues were escalated appropriately, and the trust did not have a holistic understanding of performance in end of life care. The trust did not have effective systems for identifying risks throughout the service. However, the trust engaged with patients, relatives and staff in an attempt to plan and manage appropriate services. The mortuary service held their own comprehensive risk register. The trust introduced a blue ribbon scheme to identify patients whose best interests were to remain on the ward they were already on to avoid unnecessary distress to patients and relatives.
- The rating for outpatients remained requires improvement for well-led. Processes and systems of accountability within clinical business units were not always effective. Outpatients were split over a number of different business units and there did not appear to be oversight and shared learning across all areas. We were not assured that local risk and performance was monitored appropriately. There was a lack of recorded action plans to address concerns



# Summary of findings

such as the referral to treatment times (RTT) and follow up backlog. It was unclear what actions for quality improvement had been put in place and how these were being monitored. The trust did not have processes in place to engage with patients, the general public and local organisations. The outpatient's department did not have a local vision for what it wanted to achieve. However, managers across the trust promoted a positive culture. The service was committed to improving services by learning from when things go well and when they go wrong and promoting training

- The rating for diagnostic imaging went down to inadequate for well led. The service did not have managers at all levels with the right skills and abilities to run the service. Morale amongst staff was low with staff reporting a disconnect between themselves and managers. The service leads did not engage well with staff to plan and manage the service. Systems for identifying risks were not effective. Risks were not identified and escalated, and learning was not shared. However, staff worked together and were supportive of each other.

## Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

## Areas for improvement

We found areas for improvement including 74 breaches of legal requirements that the trust must put right. We found 34 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

## Action we have taken

We found significant concerns and risks to patients within the urgent and emergency service, medicine service, end of life care and gynaecology service which were raised with the trust at the time of inspection. Many of the concerns raised had previously been identified during the inspection in 2018 yet necessary improvements had not been made.

We found that compliance with our previous enforcement actions in relation to maternity and midwifery services had either not been sustained or action effectively implemented to improve. Two of the ten conditions that were imposed on 19 July 2018, under Section 31 of the Health and Social Care Act, 2008, had not been sustained. Following the focused inspection of maternity services in December 2018 we issued a requirement notice under Regulation 17 Health and Social Care Act (RA) Regulations 2014 Good governance however there had been limited improvement since that time.

Following the core service inspection, we undertook enforcement action and told the trust it must take action to improve. We issued an urgent notice of decision under Section 31 of the Health and Social Care Act 2008, on the 18 March 2019. The notice imposed conditions on the trust registration as a service provider in respect of two regulated activities: Treatment of disease, disorder or injury and Assessment or medical treatment for persons detained under the Mental Health Act 1983. These conditions set out specific actions to enable the improvement of safety within the service.

We issued a warning notice, on the 19 March 2019, under Section 29A of the Health and Social Care Act 2008. This identified specific areas that the trust must improve and set a date for compliance as 30 April 2019. The trust initiated an immediate action improvement plan.

# Summary of findings

We undertook further enforcement action following the inspection of diagnostic imaging, in April 2019, where we found significant concerns and risks to patients. We issued an urgent notice of decision, under Section 31 of the Health and Social Care Act 2008, on the 16 May 2019, to impose conditions on the trust registration as a service provider in respect of the regulated activity: Diagnostic and Screening Procedures. These conditions set out specific actions to enable the improvement of safety within the service.

We then served a warning notice, on the 23 May 2019, under Section 29A of the Health and Social Care Act 2008. This identified specific areas that the trust must improve and set a date for compliance as 30 June 2019.

A multiagency risk summit took place on 24 April 2019.

## What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

## Areas for improvement

Action the trust **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

### Action the trust **MUST** take to improve

We told the trust that it must take action to bring services into line with legal requirements. This action related to the trust overall, all seven core services and two additional services. The core services were urgent and emergency care, medical care, surgery, maternity, services for children and young people, end of life care and outpatients. The two additional services were gynaecology and diagnostic imaging.

#### For the overall trust:

- The trust must improve the functionality of the board and ensure formalised processes are in place for the development and support of current and new executive directors and non-executive directors.
- The trust must ensure formalised processes are in place for leaders, at all levels, across the organisation in relation to engagement, performance, capability, capacity and support and ensure a programme of clinical leadership and management training and development is in place to drive improvement.
- The trust must ensure divisional leadership has the capacity to support significant improvements in the safety and quality of care and that inconsistencies across divisions are reduced.
- The trust must review, define and implement a corporate strategy aligned to clear strategic priorities. Process for assurance including risk and governance process, accountability frameworks and the board assurance framework need to be revised, aligned and implemented and effectively monitored.
- The trust must review, simplify and provide clarity to the governance, risk and quality performance processes. To improve oversight at board and provide adequate measures for assurance that quality improvement progress is being made, with robust evidence of appropriate check and challenge.
- The trust must ensure that regulatory requirements, recommendations and learnings from regulators, external reviews and local audit are utilised to identify actions for improvement and that these are monitored and reviewed effectively.

# Summary of findings

- The trust must ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant.
- The trust must ensure there is effective communication and multidisciplinary working with external providers and stakeholders.
- The trust must ensure that effective process for the management of human resources (HR) processes, including staff grievances and complaints, are in place, ensuring timely management in line with trust policy.
- The trust must ensure effective processes are in place to meet all the requirements of the fit and proper person's regulation.
- The trust must improve the culture, ownership and accountability of clinicians, at all levels across the organisation, to empower and effect change within their working specialties and areas.
- The trust must continue to improve the culture, working relationships and engagement of consultant staff across all services.
- The trust must ensure that there is an effective and consistent process for governance, quality improvement and risk management in all departments and across divisions to ensure appropriate escalation to the board.
- The trust must ensure that processes for incident reporting, investigation, actions and learning improve and become embedded across all services. The trust must ensure that incident investigations and root cause analysis are robust and identified actions and learnings are implemented and shared.
- The trust must ensure that staff completing root cause analysis or complex investigations are competent to do so.
- The trust must ensure that mandatory training attendance, including training on infection prevention and control and safeguarding of vulnerable children and adults, improves to ensure that all staff are aware of current practices and are trained to the appropriate level.
- The trust must ensure that patients are treated individually, with dignity and respect and that they are kept informed of and involved with plans for their care.
- The trust must ensure that patients individual needs are recorded, respected and met wherever possible.
- The trust must ensure patient care records are accurate, complete and contemporaneous and stored securely.
- The trust must review the knowledge, competency and skills of staff in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards.
- The trust must ensure that Deprivation of Liberty Safeguards (DoLS) are properly applied for and that training materials are accurate and supported by the Act.
- The trust must ensure mental capacity assessments are consistently and competently carried out where required.
- The trust must ensure that the duty of candour is carried out as soon as reasonably practicable, in line with national guidance.
- The trust must ensure that risks are swiftly identified, mitigated and managed. There must be robust, consistent processes in place to ensure that action plans are enacted following audit, mortality reviews, incidents and complaints. There must be clear processes for review, analysis and identification of themes and shared learning.
- The trust must ensure that effective processes are in place, and monitored, to ensure clinical policies and guidelines are regularly reviewed and updated in line with national guidance.

# Summary of findings

- The trust must continue to review the bed management and site management processes within the organisation to increase capacity and flow.
- The trust must improve staff, patient and public engagement and communication.

## **Urgent and Emergency care**

- The trust must ensure medical staffing levels are in line with national guidance.
- The trust must ensure that resuscitation trolley checks and other daily environment and equipment checks are completed in accordance with the trust policy.
- The trust must ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant.
- The trust must improve its performance times in relation to ambulance turnaround delays, four-hour target, patients waiting more than four hours from the decision to admit until being admitted and monthly median total time in A&E.
- The trust must ensure that risk assessments are undertaken for all patients presenting in the emergency department, including children, with mental health concerns and/or at risk of deliberate self-harm or suicide, and ensure that action is taken to mitigate the identified level of risk.
- This trust must ensure that appropriate levels of observation are undertaken by suitably qualified staff, when risk assessments indicate that this is necessary.
- The trust must ensure that all areas utilised for patients, including children, at risk of deliberate self-harm or suicide have had an environmental risk assessment and that actions are undertaken as identified by the assessment.
- The trust must ensure that all emergency department staff are aware of and adhere to protocols for responding to patients with mental health concerns.
- The trust must ensure that effective systems are in place for booking-in walk-in patients to ensure that patients at risk of deterioration are identified and escalated appropriately.
- The trust must ensure that an effective system is in place for the regular oversight of the waiting area for walk-in patients to ensure that patient needs are being met and patients at risk of deterioration are identified and escalated appropriately.
- The trust must ensure that there is an effective system in place to robustly clinically assess all patients who present to the emergency department in line with relevant national clinical guidelines within 15 minutes of arrival.
- The trust must ensure that the staff required to implement this system are suitably qualified and competent to carry out their roles in that system, and in particular to undertake triage, to understand the system being used, to identify and to escalate clinical risks appropriately.
- The trust must ensure that the system makes provision for effective monitoring of the patient's pathway through the department from arrival. The registered provider must ensure that this clinical assessment and the rationale for level of care provided is clearly documented in patients' records.
- The trust must ensure that clear inclusion and exclusion criteria is in place for the 'fit to sit' area in minors and that there are sufficient numbers of staff available to monitor and review patients who have been placed in the 'fit to sit' area.

# Summary of findings

- The trust must devise and implement an effective system to ensure that there are sufficient numbers of suitably qualified, skilled and experienced clinical staff throughout the emergency department to support the care and treatment of patients. The system must include provision for review and adaptation of staffing levels as required at regular intervals through the day to meet demand.

## Medical care

- The trust must ensure that all staff are trained to the appropriate level for safeguarding children and adults.
- The trust must ensure that staff follow procedures in relation to safeguarding and that any safeguarding concerns are reported without delay.
- The trust must ensure that all Control of Substances Hazardous to Health (COSHH) covered cleaning materials are securely stored and other potentially harmful items such as batteries are also secured.
- The trust must ensure that vulnerable people and the public are not exposed to the risk of very hot water.
- The trust must ensure that all equipment is appropriately portable appliance tested.
- The trust must ensure that patients at risk of deterioration are appropriately escalated for review.
- The trust must ensure that NEWS2 is appropriately used, observations completed at appropriate intervals and actions recorded.
- The trust must ensure that there is an effective system in place for agency staff to report incidents.
- The trust must ensure that national guidance for staffing in hyper acute areas is formally considered in staffing these areas.
- The trust must ensure that fluid balance charts are properly completed.
- The trust must ensure there are no mixed sex breaches in the hyper acute stroke unit (HASU).

## Surgery

- The trust must ensure that main theatre improve the use and audit of the World Health Organisation (WHO) and five steps to safer surgery checklist. Ensure that all steps are fully documented, and that sufficient audit is undertaken to ensure effective quality monitoring and improvement of patient safety.

## Maternity

- The department must ensure that all relevant processes, such as those pertaining to agency staffing, are communicated to all relevant staff and are being implemented.

## Gynaecology

- The trust must ensure that all medical and nursing staff have the appropriate completed competencies.
- The trust must ensure that the early pregnancy antenatal unit has portable oxygen and suction available.
- The trust must ensure the early pregnancy unit has the appropriate staff in place to ensure patients are safe.
- The service must ensure that robust processes are in place to monitor referral to treatment and follow up appointments effectively.

## End of life care

- The trust must address specialist palliative consultant staffing and put measures in place to improve in line with national standards.

# Summary of findings

- The trust must ensure that the executive lead for end of life care and divisional triumvirate take accountability for raising, monitoring and addressing risks in end of life care. The trust must ensure effective ownership and monitoring of performance to drive improvement within the service.
- The trust must ensure that a personalised plan of care is successfully implemented across the organisation to ensure that end of life patients receive person-centred care that meets their needs.
- The trust must ensure systems and processes are in place, and effective, to identify patients who require end of life care and to instigate an appropriate pathway.
- The trust must review the end of life strategy and ensure it includes clear actions for achieving a sustainable quality service. The strategy must be communicated to all staff.
- The trust must continue to monitor and take action to improve completion of do not attempt cardio pulmonary resuscitation (DNACPR) forms and that appropriate mental capacity assessments are undertaken for patients with a DNACPR in place.

## Diagnostic imaging

- The trust must ensure that staffing levels are adequate to provide safe care and treatment to patients in a timely way.
- The trust must be assured that the out of hours staffing arrangement is sustainable and robust to provide safe care and treatment to patients.
- The trust must ensure that Patient Group Directions (PGDs) are fit for purpose and are adhered to.
- The trust must ensure that staff have the appropriate training and competencies in place and that these are assessed and clearly recorded. This includes annual competency assessments.
- The trust must ensure that staff receive an annual appraisal.
- The trust must ensure that appropriate personal protection equipment is used when administering care to patients to prevent the spread of infection.
- The trust must ensure that an effective system is in place for the regular oversight of the appropriate escalation of significant findings, to include diagnostic imaging undertaken out of hours to ensure that any patients at risk are escalated appropriately.
- The trust must ensure that relevant clinical policies, guidelines and protocols are in place across the diagnostic imaging department to support operational activity.
- Leaders must ensure they are visible and improve relationships between staff and managers.

Action the trust SHOULD take to improve

## For the overall trust:

- The trust should ensure that effective processes are in place to promote and protect the health and wellbeing of all staff.

## Urgent and Emergency care

- The trust should ensure that plans for the redesign of the layout of the emergency department continue to progress and are implemented.
- The trust should ensure that staff receive yearly appraisals.



# Summary of findings

- The trust should ensure that work to review internal professional standards continues in a timely manner. The trust should ensure that the standards are monitored on an ongoing basis once they are in place.
- The trust should ensure that work to review the policies, protocols, processes and service provision in place to manage flow, escalation and crowding continues, and that this is monitored and reviewed on an ongoing basis.
- The trust should ensure that patients' pain levels are assessed, addressed and monitored in line with national guidance.
- The trust should ensure that patients' individual nutritional needs are assessed, addressed and monitored.
- The trust should ensure there is improved multidisciplinary working.
- The trust should ensure the service improves its local audit programme to support and monitor the implementation of national guidance.
- The trust should ensure that plans in relation to the development of a strategy for the urgent and emergency service are implemented.
- The trust should review the availability and use of communication aids and other provisions to meet patients' individual needs within the department.

## **Surgery**

- The trust should ensure that patients receive the medicines at the time they are prescribed.
- The trust should ensure patients on the 62-day pathway receive treatment in line with the national target.
- Trust should ensure there is effective processes in place for surgical specialities to review patients in the emergency department in a timely way.
- The trust should improve waiting times from referral to treatment in respect of plastic surgery, general surgery and orthopaedic surgery.

## **Maternity**

- The department should ensure that another fridge is sourced to ensure that medications are kept separately to human tissue samples to prevent cross contamination.
- The service should ensure that all equipment in all areas is checked daily as per trust guidelines.
- The service should ensure that women receiving care are given printouts of their full care to take to appointments at different maternity providers when required.
- The service should improve the representation of all grades of midwives and doctors at the weekly cardiotocograph meetings.
- The service should establish an effective information system on their trust website to inform women and their families.
- The department should ensure that all relevant maternity staff are trained and competent to implement the Gap and Grow package.
- The service should consider performing regular audits of record keeping.

## **Gynaecology**

- The service should develop and implement a clear vision and strategy.

# Summary of findings

## Services for children and young people

- The service should ensure nursing staff in NICU hand over care of the babies when leaving the nursery for an extended period of time.
- The service should obtain a portable telephone to enable staff on Rudham ward to take confidential calls in private.
- The service should continue to recruit consultants in order that they operate in line with royal college of paediatric and child health (RCPCH) guidance.
- The service should ensure consultant handwriting is legible in all medical records.
- The service should ensure representation of the CYP service at mortality review meetings.
- The service should ensure staff are aware of the CYP strategy.
- The service should monitor the progress of the implementation of the strategy.
- The service should ensure oversight of CYP services through discussions at all levels of governance

## Outpatients

- The service should ensure that there is a referral to treatment (RTT) recovery plan in place for all specialities and this is monitored effectively.
- The service should develop and implement a clear vision and strategy.
- The service should ensure that all outpatient areas audit the effectiveness of care and treatment and use the findings to improve.

## Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

- The delivery of high-quality care was not assured by the leadership, governance or culture across the organisation. There had been significant changes in the executive leadership team which meant leadership was not stable at an executive level. Within the executive team there were significant capability and capacity challenges.
- Not all managers at all levels in the trust had the right skills and abilities to run a service. There was a disconnect between executive and divisional leadership, inconsistencies in leadership between the two divisions and variability across the clinical business units.
- There had been limited development of the executive team. Board development sessions that had taken place failed to focus on addressing team shortcomings and there had been no attention to succession planning. Wider leadership development across the organisation had not taken place. This meant the trust had failed to address previous concerns.
- Leaders across the trust were working in silos and were not actively taking clinical responsibility, or ownership, for the actions to drive improvement. There remained a lack of engagement from the consultant body and resistance to accepting accountability from senior clinicians. Where actions had been identified as required there was limited follow up to ensure that these had been completed and concerns addressed.

# Summary of findings

- There was a lack of oversight and accountability from the board. Robust check and challenge to ensure that actions outlined were undertaken to drive improvements in performance and reduce the risks to patient safety had not been undertaken. It was evident that there had been an overly positive culture in place with a prevailing level of acceptance rather than adequate assurance being sought. The relationship between the executive directors and NEDs was described as transactional not transformational.
- Arrangements in place to ensure that directors were fit to carry out their responsibility in accordance with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 remained inconsistent.
- The trust had no clear vision or credible strategy in place and links to the sustainability and transformation plan (STP) were tentative. There were no realistic objectives or robust plans to enable the delivery of high quality sustainable care to patients.
- The culture within the organisation did not support proactive anticipation of risks. Escalation and the ability / willingness of staff to challenge and discuss options for mitigating risk had a direct impact on the slow pace of change and improvement.
- Governance structures, systems and processes were not effective. There was no effective process in place to review key items such as the strategy, values, objectives, plans or governance framework. We found that governance systems were overly complicated, committees were working independently in silos, reporting routes were ineffective and inconsistent and questionable data was being escalated to the board.
- Arrangements for risk, issues and performance remained ineffective with continued significant failings in performance management and audit systems. Clinical and internal audit processes were inconsistent in their implementation and impact. Risk, issues and poor performance were not dealt with in a consistent, appropriate or timely manner.
- The quality improvement programme (QIP) had grown into an unmanageable document that meant focus and pace to act and effect change had been lost. Due to significant concerns we undertook regulatory action post inspection. A significant number of our concerns had been raised previously and not been addressed.
- There was a disparity between the ownership, accountability and experience of triumvirate leads across the two divisions. Senior leaders in division two were unable to describe the risk management process in operation or to clearly identify levels of responsibility amongst their triumvirate.
- Processes to recognise, identify and respond to incidents and emerging themes was slow. We were not assured that actions were being taken in a timely manner or that, when implemented, measures were being monitored to improve patient safety. Lessons learnt were not effectively shared to reduce the risk to others. The trust had been issued with a Regulation 28 report to prevent future deaths from the coroner as they had failed to implement proposed actions within the stipulated timeline.
- Across several core services we found that patient risk assessments were not fully completed. Risk registers were either not in place at all, such as end of life care, or had not been maintained. Risks on the registers had passed dates for review and registers were not updated.
- Systems and process were still not robust to identify and learn from unanticipated deaths. There had been limited improvements made, with inaccurate minutes, continued reluctance amongst clinicians to declare avoidable deaths, ineffective process to share learning and no involvement from relative and carers and no family liaison in place.
- The information used to monitor performance and to make decisions was inaccurate and unreliable. Finance, quality management and risk were not integrated effectively to support decision making.

# Summary of findings

- There was a limited approach to sharing information with, and obtaining the views of, staff, patients, people who use the services and external partners and stakeholders. Where feedback was received, actions to effect change had been slow.
- Robust systems and process for learning, continuous improvement and innovation were not in place. There was a limited focus on continuous learning and improvement, with initiatives seen in isolation in certain areas. Systems and process remained ineffective to identify and learn from unanticipated deaths.
- Equality and diversity were not actively promoted within the organisation and actions identified as being introduced in 2018 had not taken place. The published equality and diversity system 2 (EDS2) action plan for the trust was dated 2015. The equality and diversity strategy was in process, at the time of inspection, and was due to be ratified by the board in June 2019.

However:

- The new chief executive officer and the new chairman were receptive and responsive to the concerns we raised during the inspection. It was recognised by the chief executive and chair that the multiple changes in the senior leadership team now presented the trust with the opportunity to engage experienced executives who would be able to support and develop staff to drive improvement.
- Board development and wider leadership development had been recognised as a priority. A review of capability and capacity of leadership across the divisions had been undertaken and triumvirate leads for each division had been required to sign a revised scope of responsibility. We were informed that a wider organisational development plan to support development and succession planning would be undertaken.
- The introduction of an accountability framework in February 2019 was the first step in outlining to the divisions a level of accountability for performance improvement delivery that had not been present or formalised previously.

## Ratings tables

| Key to tables                           |           |               |                      |                 |                  |
|-----------------------------------------|-----------|---------------|----------------------|-----------------|------------------|
| Ratings                                 | Not rated | Inadequate    | Requires improvement | Good            | Outstanding      |
| Rating change since last inspection     | Same      | Up one rating | Up two ratings       | Down one rating | Down two ratings |
| Symbol *                                | →←        | ↑             | ↑↑                   | ↓               | ↓↓               |
| Month Year = Date last rating published |           |               |                      |                 |                  |

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

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

### Ratings for the whole trust

| Safe                         | Effective                   | Caring                                | Responsive                             | Well-led                     | Overall                      |
|------------------------------|-----------------------------|---------------------------------------|----------------------------------------|------------------------------|------------------------------|
| Inadequate<br>→←<br>Jul 2019 | Inadequate<br>↓<br>Jul 2019 | Requires improvement<br>↓<br>Jul 2019 | Requires improvement<br>→←<br>Jul 2019 | Inadequate<br>→←<br>Jul 2019 | Inadequate<br>→←<br>Jul 2019 |

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

## Rating for acute services/acute trust

|                                              | Safe                                  | Effective                   | Caring                                | Responsive                            | Well-led                              | Overall                               |
|----------------------------------------------|---------------------------------------|-----------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| Urgent and emergency care                    | Inadequate<br>↔<br>Jul 2019           | Inadequate<br>↓<br>Jul 2019 | Requires improvement<br>↓<br>Jul 2019 | Requires improvement<br>↔<br>Jul 2019 | Inadequate<br>↔<br>Jul 2019           | Inadequate<br>↔<br>Jul 2019           |
| Medical care (including older people's care) | Inadequate<br>↔<br>Jul 2019           | Inadequate<br>↓<br>Jul 2019 | Requires improvement<br>↔<br>Jul 2019 | Requires improvement<br>↔<br>Jul 2019 | Inadequate<br>↔<br>Jul 2019           | Inadequate<br>↔<br>Jul 2019           |
| Surgery                                      | Requires improvement<br>↔<br>Jul 2019 | Good<br>↑<br>Jul 2019       | Good<br>↔<br>Jul 2019                 | Requires improvement<br>↔<br>Jul 2019 | Good<br>↑<br>Jul 2019                 | Requires improvement<br>↔<br>Jul 2019 |
| Critical care                                | Good<br>Jul 2015                      | Good<br>Jul 2015            | Good<br>Jul 2015                      | Good<br>Jul 2015                      | Good<br>Jul 2015                      | Good<br>Jul 2015                      |
| Maternity                                    | Requires improvement<br>↑<br>Jul 2019 | Good<br>↑<br>Jul 2019       | Good<br>↔<br>Jul 2019                 | Good<br>↑↑<br>Jul 2019                | Requires improvement<br>↑<br>Jul 2019 | Requires improvement<br>↑<br>Jul 2019 |
| Gynaecology                                  | Requires improvement<br>Jul 2019      | Good<br>Jul 2019            | Good<br>Jul 2019                      | Requires improvement<br>Jul 2019      | Requires improvement<br>Jul 2019      | Requires improvement<br>Jul 2019      |
| Services for children and young people       | Good<br>↔<br>Jul 2019                 | Good<br>↔<br>Jul 2019       | Good<br>↔<br>Jul 2019                 | Good<br>↔<br>Jul 2019                 | Requires improvement<br>↓<br>Jul 2019 | Good<br>↔<br>Jul 2019                 |
| End of life care                             | Requires improvement<br>↔<br>Jul 2019 | Inadequate<br>↔<br>Jul 2019 | Good<br>↔<br>Jul 2019                 | Inadequate<br>↓↓<br>Jul 2019          | Inadequate<br>↓<br>Jul 2019           | Inadequate<br>↓<br>Jul 2019           |
| Outpatients                                  | Good<br>↑<br>Jul 2019                 | Not rated                   | Good<br>↔<br>Jul 2019                 | Requires improvement<br>↔<br>Jul 2019 | Requires improvement<br>↔<br>Jul 2019 | Requires improvement<br>↔<br>Jul 2019 |
| Diagnostic Imaging                           | Inadequate<br>↓<br>Jul 2019           | Not rated                   | Good<br>↔<br>Jul 2019                 | Requires improvement<br>↔<br>Jul 2019 | Inadequate<br>↓<br>Jul 2019           | Inadequate<br>↓<br>Jul 2019           |
| <b>Overall trust</b>                         | Inadequate<br>↔<br>Jul 2019           | Inadequate<br>↓<br>Jul 2019 | Requires improvement<br>↓<br>Jul 2019 | Requires improvement<br>↔<br>Jul 2019 | Inadequate<br>↔<br>Jul 2019           | Inadequate<br>↔<br>Jul 2019           |

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



# The Queen Elizabeth Hospital

Gayton Road  
Kings Lynn  
Norfolk  
PE30 4ET  
Tel: 01553 613613  
[www.qehkl.nhs.uk](http://www.qehkl.nhs.uk)

## Key facts and figures

The Queen Elizabeth Hospital King's Lynn is an established 488 bed general hospital on the outskirts of King's Lynn, Norfolk.

The hospital provides a comprehensive range of acute and emergency services that include, but are not limited to, cardiology, care of the elderly, children's services, dermatology, endoscopy, clinical health psychology, a range of surgical specialties, fertility services, gastroenterology, neurophysiology, nutrition and dietetics, oncology, respiratory medicine and rehabilitation services.

The core service inspection covered seven core services and two additional services: urgent and emergency care, medicine, surgery, children and young people, maternity, end of life care, outpatients, gynaecology and diagnostic imaging.

During the inspection the team spoke with 361 members of staff, 82 patients and relatives and reviewed 129 records. We also reviewed information provided to us by the trust.

## Summary of services at The Queen Elizabeth Hospital

**Inadequate** ● → ←

Our rating of services stayed the same. We rated it them as inadequate because:

- Staff did not always identify, monitor and respond appropriately to changing risks to people who used services, including deteriorating health and behaviour that challenges.
- The numbers and skill mix of nursing staff were not always suitable for the needs of the patients and medical staffing establishment levels were not in line with national guidance.
- The number of staff completing mandatory training fell far short of the trust's targets for all subjects and staff groups. Not all staff understood how to protect patients from abuse.
- Risk assessments for patients were not always completed or updated appropriately and action was not always taken to remove or minimise risks. Not all staff identified and acted quickly upon patients at risk of deterioration.
- Staff did not always ensure that information relating to a patients' care and treatment was appropriately recorded. Records systems did not support staff to deliver safe care and treatment.

# Summary of findings

- Not all services had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff did not protect patients' dignity when providing care or protect their privacy when discussing them. Staff did not always treat patients with compassion and kindness or take account of their individual needs.
- The design, maintenance and use of facilities and premises did not always keep patients safe, particularly those with mental health concerns.
- The arrangements for investigating incidents and for implementing changes to practice as a result of learning from serious incidents and deaths was not robust. Investigations lacked appropriate detail, themes were not always identified, and learnings were not effectively shared. Follow up to ensure changes had been implemented was poor. Duty of candour was not being consistently carried out when required.
- Monitoring results to improve safety and assess the effectiveness of care and treatment was inconsistent, when in place this was not robust. The accuracy and validity of data being utilised to monitor care was questionable.
- Care and treatment was not always based on current national guidance and best practice. Managers did not always check to ensure staff followed guidance.
- Staff did not always protect the rights of patients' subject to the Mental Health Act 1983. Staff did not always understand the relevant consent and decision making requirements of the Mental Capacity Act 2005. We were not assured that staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.
- Audit activity to support and monitor the implementation of national guidance was limited. When local audit was used, this was not utilised fully, and action plans were not monitored or reviewed effectively to ensure improvement in services. Performance in national audits was mixed, with limited evidence of learning and action taken to improve performance.
- Patient's needs, such as specific nutrition and hydration and pain levels, were not being identified and monitored appropriately in all areas across the hospital. Patients at the end of life were not always identified. Systems and processes were not always in place to meet patient's individual needs.
- Staff competency was not monitored effectively in all areas to ensure staff had the right skills and abilities to provide appropriate care. Appraisals were inconsistent and supervision meetings to provide support and development were not always in place.
- People could not access care and treatment in a timely way. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.
- The service did not investigate concerns and complaints thoroughly to enable lessons to be learned and shared with all staff. The service did not include patients in the investigation of their complaint.
- Not all leaders had the integrity, skills and abilities to run services. Not all recognised, understood or managed the priorities and issues that their service faced. Staff were not always supported to develop their skills and take on more senior roles.
- Not all services had a vision for what they wanted to achieve and a strategy to turn this into action. In those that did, leaders and staff did not always fully understand or know how to apply them and monitor progress.
- Positive multidisciplinary working was not in place across all areas in the hospital. Services and divisions were working in silos. Culture and morale remained poor with limited evidence of shared learning and benchmarking to improve services. Where staff felt able to raise concerns they felt that these were not always listened to or addressed.

# Summary of findings

- Governance processes and systems to manage risk, issues and performance were not effective. Staff, at all levels, were not always clear about their roles and accountabilities. systems to manage performance effectively. Risks were not always identified and escalated to reduce their impact. Plans to cope with unexpected events were not always in place. Staff did not always contribute to decision-making to improvements in quality of care.
- Leaders and staff did not always actively and openly engage with patients, staff, equality groups, the public and local organisations to plan and manage services. There was limited collaboration with partner organisations to help improve services for patients.

However:

- There were systems and processes in place to monitor standards of cleanliness and hygiene. In the main infection control and prevention was handled well.
- There were systems and processes in place for medicine management to prescribe, administer, record and store medicines.

The appointments of a new chairman and chief executive was seen as a positive. There were actions being taken to increase the level of engagement of staff across the hospital and staff recognition schemes had been reintroduced.

- There were pockets of cohesive team working with learning, continuous improvement and innovation in some areas and departments.

# Urgent and emergency services

Inadequate   

## Key facts and figures

The emergency department at The Queen Elizabeth Hospital provides care for the local population 24 hours a day, seven days a week.

From August 2017 to July 2018 there were 63,917 attendances at the trust's urgent and emergency care services. The department was originally built for 40,000 attendances.

Out of all attendances, 39.7% resulted in admission to hospital, which is higher than the England average.

The department has a resuscitation room with three adult bays and one paediatric bay. The majors area has eight cubicles and the minors area has four cubicles and a 'fit to sit area with eleven chairs.

The paediatric area of the emergency department is open 24 hours a day, seven days a week and has three cubicles.

The adult emergency department has a dedicated mental health room.

There is an entrance for patients that self-present to the department and a dedicated entrance for ambulance arrivals.

The last inspection of the department took place in 2018, where urgent and emergency services were rated inadequate overall. Safe and well-led were rated inadequate, effective and responsive were rated requires improvement and caring was rating good. The inspection found a range of concerns including relating to staffing, environment and equipment, processes for the identification of patients at risk of deterioration, learning from incidents and audits, access and flow through the department, risk management, governance, and leadership.

We carried out an announced inspection of urgent and emergency care services on the 5 to 7 March 2019. During the inspection visit, the inspection team spoke with 38 members of staff, including nursing staff, health care assistants, doctors, housekeeping staff, administrative staff, and managers. We also spoke with two paramedics from the local ambulance trust, three members of staff from the rapid assessment team (RAT), three safeguarding leads, and a member of staff from the mental health liaison team, provided by the local mental health trust. We spoke to 19 patients and relatives and reviewed 30 patient records.

We found significant concerns in relation to the urgent and emergency service which we raised with the trust executive directors on site. Following the core service inspection, we issued an urgent notice of decision to impose conditions on the trust's registration as a service provider on 18 March 2019 in respect of the urgent and emergency service, under section 31 of the Health and Social Care Act, 2008. These conditions set out specific actions to enable the improvement of safety within the service. We also issued a warning notice on 19 March 2019 under Section 29A of the Health and Social Care Act 2008. This identified areas that the trust must improve and set a date for compliance as of 30 April 2019.

## Summary of this service

Our rating of this service stayed the same. We rated it as inadequate because:

- The service did not always ensure that staff identified, monitored and responded appropriately to changing risks to people who used services, including deteriorating health and behaviour that challenges.

# Urgent and emergency services

- The numbers and skill mix of nursing staff were not always suitable for the needs of the emergency department and medical staffing establishment levels were not in line with national guidance.
- The arrangements for investigating incidents and for implementing changes to practice as a result of learning from serious incidents and deaths were not always robust. Duty of candour was not being consistently carried out when required.
- Staff did not always ensure that information relating to a patients' care and treatment was appropriately recorded. Records systems did not support staff to deliver safe care and treatment.
- The design and use of facilities and premises in the emergency department did not always keep patients with mental health concerns safe.
- We observed examples of care which demonstrated that national guidance was not always being followed in the department. There remained concerns about a significant number of out of date guidelines and policies.
- Audit activity to support and monitor the implementation of national guidance was limited due to staffing shortages. Performance in national audits was mixed. There was limited evidence of learning and action when national audit results were in the lower UK quartile.
- Patients with specific nutrition and hydration needs were not always identified and monitored appropriately.
- Patients' pain levels were not always identified and monitored appropriately.
- There was not always evidence of positive multidisciplinary working in the urgent and emergency service.
- Staff did not always understand the relevant consent and decision making requirements of the Mental Capacity Act 2005.
- The privacy and dignity of patients was not always maintained. Staff members did not always display an understanding and non-judgemental attitude when talking about patients and relatives. There was mixed feedback from patients about the care provided by staff.
- People could not access care and treatment in a timely way. The issues impacting upon flow had not been addressed since the time of our last inspection.
- The department had not always ensured that systems and processes were in place to meet patient's individual needs.
- There had been an 83.7% increase in the number of complaints since our last inspection and it took an average of 33 working days to investigate and close complaints.
- Leaders either had not identified or had not taken action to address some of the concerns that we identified during our current or last inspection. Not all risks identified during our current inspection or our last inspection had been included on the risk register.
- Leaders did not receive sufficient support or time to undertake their leadership roles effectively and maintain sufficient oversight over the department.
- There was no separate formal strategy for urgent and emergency services.
- Staff felt able to raise concerns but did not feel that these were always listened to or addressed.

However:

- Medicines were managed and administered appropriately.
- The department had improved the oversight over the completion of competencies.

# Urgent and emergency services

- The new emergency department matron had taken action to increase the level of engagement of staff in the department.
- There was a range of evidence of learning, continuous improvement and innovation within the ambulatory emergency care unit.

## Is the service safe?

**Inadequate** ● → ←

Our rating of safe stayed the same. We rated it as inadequate because:

- We identified concerns regarding a range of patients during our inspection which demonstrated that staff did not always identify, monitor and respond appropriately to deteriorating patients.
- Non-clinical reception staff made decisions about the escalation of patients who may require urgent review without formal guidelines with clear red flag symptoms to base these decisions on. There was a lack of clinical oversight over the walk-in waiting area. These concerns were identified during our last inspection and had not been appropriately addressed.
- The department was not appropriately assessing or managing the risk for patients who attended the department with mental health concerns.
- The numbers and skill mix of nursing staff were not always suitable for the needs of the emergency department. There were significant vacancy and turnover rates for both nursing staff and as a result, the department was reliant on a significant amount of bank, agency staff. The movement of nursing staff around the department raised concerns about the impact on patient safety.
- The emergency department coordinator was not supernumery which impacted on their ability to oversee the department and appropriately monitor patient safety and escalating capacity concerns.
- Medical staffing establishment levels were not in line with national guidance. There were no consultants with sub-specialty training in paediatrics. We observed a lack of medical leadership or coordination in the management of patients within the department. On the first day of inspection the consultants on duty were not working within the department itself.
- The arrangements for investigating and learning from serious incidents were not always robust. Duty of candour was not being consistently carried out when required.
- Whilst there was evidence that the department now fed into mortality and morbidity meetings, actions were not routinely identified to ensure that learning from reviews was implemented appropriately.
- Staff did not always ensure that information relating to a patients' care and treatment was appropriately recorded. Records systems did not support staff to deliver safe care and treatment.
- The design and use of facilities and premises in the emergency department did not always keep patients with mental health concerns safe. There was not always evidence of regular review of resuscitation equipment or the completion of other daily checks on the environment and equipment.
- Mandatory training completion rates for urgent and emergency care had improved since our last inspection but was still not meeting the trust target. Completion rates for certain courses was particularly low, such as safeguarding level three for medical staff.

However:



# Urgent and emergency services

- Medicines were managed and administered appropriately.

## Is the service effective?

**Inadequate** ● ↓

Our rating of effective went down. We rated it as inadequate because:

- We observed examples of care which demonstrated that national guidance was not always being followed in the department.
- Audit activity to support and monitor the implementation of national guidance was limited due to staffing shortages.
- Performance in national audits was mixed. There was limited evidence of learning and action when national audit results were in the lower UK quartile.
- There remained concerns about a significant number of out of date guidelines and policies.
- Patient's with specific nutrition and hydration needs were not always identified and monitored appropriately.
- Patients did not always receive a timely assessment of their pain or have timely access to pain relief. The service was not undertaking any audits relating to pain relief.
- There was not always evidence of positive multidisciplinary working in the urgent and emergency service.
- Staff gave inconsistent answers as to their understanding and responsibilities under the Mental Capacity Act 2005. Training completion rates were below the trust target. Mental capacity assessments had not been carried out in the records we reviewed.
- Appraisal rates had improved from our previous inspection but were still not meeting the trust target.

However:

- The department had improved the oversight over the completion of competencies.

## Is the service caring?

**Requires improvement** ● ↓

Our rating of caring went down. We rated it as requires improvement because:

- The privacy and dignity of patients was not always maintained. Doors were not always closed, or curtains not always drawn to ensure patients' privacy and dignity was protected.
- Staff members did not always display an understanding and non-judgemental attitude when talking about patients and relatives.
- There was mixed feedback from patients about the care provided by staff. This included around whether staff had involved patients in decisions about their care and treatment, and the emotional support provided by staff.

However:

- We also observed many examples of caring interactions between staff and patients during our inspection.

# Urgent and emergency services

## Is the service responsive?

**Requires improvement**   

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

- People could not access care and treatment in a timely way. Performance was worse than the national average regarding the percentage of patients waiting more than four hours from decision to admit until being admitted, four hour target performance, median time from arrival to treatment, and median total time in urgent and emergency care. There were significant delays in ambulance turnaround times.
- The issues impacting upon flow had not been addressed since the time of our last inspection. The issues included the allocation and movement of staff, the layout of the department, the availability and capacity of admission avoidance provision, delays in the assessment and treatment of patients with mental health concerns, areas within the department not being used as intended, and the policies and protocols in place to manage escalation and crowding.
- The department had not always ensured that systems and processes were in place to meet patient's individual needs.
- There had been an 83.7% increase in the number of complaints since our last inspection and it took an average of 33 working days to investigate and close complaints, which was not in line with the trust's complaints policy.

However:

- The department had improved the service provision for children, with a wall mural, ceiling lights and a wall projector in the paediatric resuscitation bay, interactive sensory wall panels in the paediatric waiting area, and an expanded waiting area to better accommodate the number of visitors to the department.
- There was evidence that the department was reviewing service provision to ensure that services reflected the needs of the population served. This included the development of short, medium and long term plans for the redesign of the department, and work towards implementing streaming in the department.
- The rapid assessment team (RAT) worked to ensure that appropriate discharge arrangements were in place for people with complex health and social care needs. The team carried out comprehensive assessments of health and social care needs and then worked to address these in order to facilitate discharge.

## Is the service well-led?

**Inadequate**   

Our rating of well-led stayed the same. We rated it as inadequate because:

- Leaders had not taken action to address some of the concerns that we identified during our inspection. Whilst the trust was responsive to concerns raised during our inspection, this indicated that leaders were reactive rather than proactive in identifying and addressing concerns.
- Action had not been taken to address some concerns identified during our previous inspection in 2018.
- Not all risks identified during our current inspection or our last inspection had been included on the risk register.
- The emergency department matron and clinical lead did not receive sufficient support or time to undertake their leadership roles effectively and maintain sufficient oversight over the department.

# Urgent and emergency services

- Senior nurse coordinators provided day-to-day management in the department but were usually not supernumerary and this limited the time that they had available to provide leadership.
- There was no separate formal strategy for urgent and emergency services. This meant that the department did not have clear objectives to work towards and did not regularly assess whether progress was being made.
- Staff felt able to raise concerns but did not feel that these were always listened to or addressed.
- There were not always effective arrangements in place to ensure that the information used to monitor, manage and report on quality and performance was accurate, valid, reliable, timely and relevant.
- The processes that were in place to give leaders an oversight of performance were not always being utilised effectively to drive improvement.

However:

- The new emergency department matron had taken action to increase the level of engagement of staff in the department.
- There was a range of evidence of learning, continuous improvement and innovation within the ambulatory emergency care unit.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Medical care (including older people's care)

Inadequate   

## Key facts and figures

The trust provides a comprehensive medical service within inpatient and outpatient settings. The trust has two care of the elderly wards, one of these being a specialist environment for the care of patients with dementia, and the trust has a full-time orthogeriatric consultant.

There is a seven-day service consultant-led frailty unit. The trust's stroke services has a hyper-acute stroke unit (HASU) with four thrombosis beds, supported by further acute and rehab beds. Stroke and transient ischemic attack (TIA) are seven-day service, and there is a thrombosis nurse on-site 24/7.

The endoscopy unit is JAG accredited, and there is a 24/7 GI Bleed rota supported by gastroenterology and general surgery. There is an on-site satellite dialysis unit operated by Addenbrookes. The trust has three coronary care unit (CCU) beds, cardiology monitored beds and a dedicated cardiology in-reach service for the medical assessment unit (MAU).

There is a respiratory ward, and in-reach is provided seven days per week. The endocrine and diabetes service is consultant-led, supported by diabetes clinical nurse specialists. The diabetes service runs insulin pump clinics and outreach community education to reduce incidence and hospital attendance.

Rheumatology has four clinical nurse specialists supporting the consultants. There is a full range of specialist neurology clinics, including memory, motor neurone disease (MND) and injection. The trust also has a consultant liaison service to provide support to two local community hospitals.

The trust had 41,533 medical admissions from October 2017 to September 2018. Emergency admissions accounted for 21,561 (51.9%), 238 (0.6%) were elective, and the remaining 19,734 (47.5%) were day case.

We inspected this service in 2018 and rated it inadequate. During this inspection we visited seven clinical areas, spoke with 41 staff, patients, relatives and carers, observed care and reviewed records.

We found significant concerns in relation to the medical care service which we raised with the trust executive directors on site. Following the core service inspection, we issued a warning notice on 19 March 2019 under Section 29A of the Health and Social Care Act 2008. This identified areas that the trust must improve and set a date for compliance as of 30 April 2019.

We rated the service inadequate.

## Summary of this service

Our rating of this service stayed the same. We rated it as inadequate because:

- The service did not manage patient safety incidents well. Staff recognised incidents, but the quality of investigations was not always robust. Staff were not trained to complete root cause analysis or investigate complex issues.
- The service did not control infection risk well. We saw a number of examples of poor infection control practice in ward areas.
- The service did not ensure that premises was safe. There were control of substances hazardous to health (COSHH) breaches and risks associated with extremely hot water in unsecured sluice rooms.
- The service did not store medicines well. We saw examples of poorly managed and stored intravenous fluids.

# Medical care (including older people's care)

- Staff did not keep appropriate records of patients' care and treatment. Records were not clear, did not contain a plan of care, there were frequent omissions in records and they were not secure.
- Staff did not understand how to protect patients from abuse. Staff gave inconsistent responses in how to raise safeguarding concerns and failed to act on a safeguarding issue.
- The service provided mandatory training in key skills to all staff but not all staff had completed it.
- The service did not have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. There remained a very high vacancy rate for nursing staff with frequent use of agency. There was a reliance on locum doctors in a number of areas.
- The service did not provide care and treatment based on national guidance.
- The service did not monitor the effectiveness of care and treatment. We saw examples of poor audit results such as NEWS2 audit which were not repeated to measure improvement. Records audits showed consistently poor results without significant improvement.
- Staff did not always have access to up-to-date, accurate and comprehensive information on patients' care and treatment.
- Staff did not understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Staff gave inconsistent responses when asked about the MCA. We found instances where the MCA was not properly considered.
- Staff did not always care for patients with compassion. We saw numerous instances of neutral care interactions and occasions when a small number of staff appeared indifferent to their caring role. Three people complained about long call bell waits and we observed a number of occasions when call bells were slow to be answered.
- Staff did not always involve patients and those close to them in decisions about their care and treatment. Several patients and relatives told us they had to ask multiple times for information relating to their care. We observed two relatives who had not been informed of changes in care of their family member.
- The service did not take account of patients' individual needs. We saw and heard examples of the service failing to meet the needs of patients.
- The service was slow to respond to complaints, even those requiring a simple explanation.
- The trust did not have managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. There was a significant lack of improvement since our last inspection and lack of capacity in divisional leadership to effect sustainable change.
- The service did not have a coherent vision or strategy. Staff did not identify with the division's priorities. They did however relate to the trust values and vision.
- The culture was mixed in the division. Some staff told us of improvements however, we had received whistle blowing information prior to the inspection from concerned staff. We were aware of examples of poor communication in the service that impacted staff morale.
- The trust did not have effective systems for identifying risks. Some risks on the risk register had been on the register for up to eight years. We identified risks that the service had not addressed, and the service had failed to act on known past risks.
- The trust did not trust collect or use information well; information had not been used to drive improvements.

# Medical care (including older people's care)

- There was insufficient evidence to demonstrate that the trust was committed to improving services by learning. There had been no significant improvement since our last inspection. The service had failed to learn from previous concerns raised by the coroner under regulation 28.

However:

- The service planned for emergencies and staff understood their roles if one should happen.
- There had been improvements in nurse shift fill rates.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff provided emotional support to patients to minimise their distress. We saw some excellent examples of individual emotional support such as by a care assistant on Necton Ward.
- The trust planned and provided services in a way that met the needs of local people.
- People could access the service when they needed it. Waiting times from treatment were and arrangements to admit, treat and discharge patients were in line with good practice.

## Is the service safe?

**Inadequate** ● ➡ ➡

Our rating of safe stayed the same. We rated it as inadequate because:

- The service did not manage patient safety incidents well. Staff recognised incidents, but the quality of investigations was not always robust. Staff were not trained to complete root cause analysis or investigate complex issues.
- The service did not control infection risk well. We saw a number of examples of poor infection control practice in ward areas.
- The service did not ensure that premises was safe. There were control of substances hazardous to health (COSHH) breaches and issues with hot water in unsecured sluice rooms.
- The service did not store medicines well. We saw examples of poorly managed and stored intravenous fluids.
- Staff did not keep appropriate records of patients' care and treatment. Records were not clear, did not contain a plan of care, there were frequent omissions in records and they were not secure.
- Staff did not understand how to protect patients from abuse. Staff gave inconsistent responses in how to raise safeguarding concerns and failed to act on a safeguarding issue.
- The service provided mandatory training in key skills to all staff but not all staff had completed it.
- The service did not have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. There remained a very high vacancy rate for nursing staff with frequent use of agency. There was a reliance on locum doctors in a number of areas.

However:

- The service planned for emergencies and staff understood their roles if one should happen.



# Medical care (including older people's care)

- There had been improvements in nurse shift fill rates.

## Is the service effective?

**Inadequate** ● ↓

Our rating of effective went down. We rated it as inadequate because:

- The service did not provide care and treatment based on national guidance and evidence of its effectiveness.
- The service did not monitor the effectiveness of care and treatment. We saw examples of poor audit results such as NEWS2 audit which were not repeated to measure improvement. Records audits showed consistently poor results without significant improvement.
- Staff did not always have access to up-to-date, accurate and comprehensive information on patients' care and treatment.
- Staff did not understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Staff gave inconsistent responses when asked about the MCA. We found instances where the MCA was not properly considered. Only 32% of medical staff had completed training in the MCA.
- The trust was unable to provide an action plan in relation to poor performance in the 2017 Lung Cancer Audit.
- Patients in general medicine, geriatric medicine and respiratory medicine had a higher than expected risk of readmission for non-elective admissions. Readmission rates varied significantly from ward to ward.

However:

- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- The Sentinel Stroke National Audit Programme (SSNAP) showed a grade A in the latest audit which was the best in the region.

## Is the service caring?

**Requires improvement** ● → ←

Our rating of caring stayed the same. We rated it as requires improvement because:

- Staff did not always care for patients with compassion. We saw numerous instances of neutral care interactions and occasions when a small number of staff appeared indifferent to their caring role.
- Staff did not always involve patients and those close to them in decisions about their care and treatment. Several patients and relatives told us they had to ask multiple times for information relating to their care. We observed two relatives who had not been informed of changes in care of their family member.

However:

- Staff provided emotional support to patients to minimise their distress. We saw some examples of individual care and support such as by a care assistant on Necton Ward.

# Medical care (including older people's care)

## Is the service responsive?

**Requires improvement**   

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

- The service did not take account of patients' individual needs. We saw and heard examples of the service failing to meet the needs of patients.
- The service was slow to respond to complaints, even those requiring a simple explanation.

However:

- The trust planned and provided services in a way that met the needs of local people.
- People could access the service when they needed it. Waiting times for treatment and arrangements to admit, treat and discharge patients were in line with good practice.

## Is the service well-led?

**Inadequate**   

Our rating of well-led stayed the same. We rated it as inadequate because:

- The trust did not have managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. There was a significant lack of improvement since our last inspection and lack of capacity in divisional leadership to effect sustainable change.
- The service did not have a coherent vision or strategy. Staff did not identify with the division's priorities. They did however relate to the trust values and vision.
- The culture was mixed in the division. Some staff told us of improvements however, we had received whistle blowing information prior to the inspection from concerned staff. We were aware of examples of poor communication in the service that impacted staff morale.
- The trust did not have effective systems for identifying risks. Some risks on the risk register had been on the register for up to eight years. We identified risks that the service had not addressed, and the service had failed to act on known past risks.
- The trust did not trust collect or use information well; information had not been used to drive improvements.
- There was insufficient evidence to demonstrate that the trust was committed to improving services by learning. There had been no significant improvement since our last inspection. The service had failed to learn from previous concerns raised by the coroner under regulation 28.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Surgery

Requires improvement   

## Key facts and figures

The trust has seven surgical wards/units with 138 inpatient beds, one main operating theatre suite and a day surgery unit. It covers a range of elective and emergency surgical services, including general and breast surgery, upper and lower gastrointestinal (GI) surgery, trauma and orthopaedics, urology, ophthalmology, ear nose and throat (ENT), oral surgery, gynaecology, chronic pain and endoscopy at The Queen Elizabeth Hospital and St George's Medical Centre.

The department has access to 12 theatres (four in the day surgery unit), eight in the main theatre complex, one of which is an obstetric theatre. Elective surgery is provided from Monday to Saturday. There are two emergency theatres which run every day, both provide 24 hour a day care.

Surgery had 2,158 elective admissions, 3,956 emergency admissions and 19,196 day-case surgeries from December 2017 to November 2018. All elective patients are assessed pre-operatively by nurses in the pre-assessment unit and, where appropriate, by a consultant anaesthetist.

Our inspection of The Queen Elizabeth Hospital was announced. Prior to our inspection we reviewed data we held about the service along with information we requested from the trust.

During the inspection we spoke with 32 members of staff including doctors, nurses, therapists, health care assistants and non-clinical staff. We spoke with 11 patients and their relatives, reviewed 13 patient records and considered other pieces of information and evidence to come to our judgement and ratings.

## Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- Staff did not always complete mandatory training in line with the trust's target. Medical staff had not completed any mandatory training modules to in line with the trust's
- Medical staff did not always complete training to recognise and safeguard patients from abuse. However, nursing staff had training on how to recognise and report abuse, and they knew how to apply it.
- There had been no improvement in the quality audits relating to the World Health Organisation (WHO) and five steps to safer surgery checklist in main theatres. The service had failed to respond and adequately improve compliance with all five steps to improve patient safety.
- The service did not always have enough nursing staff to keep people safe from avoidable harm and to provide the right care and treatment.
- Patients did not always receive their medication at the right time. However, the service followed best practice when prescribing, recording and storing medicines.
- People could not always access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with good practice.
- The timeliness of complaint responses did not meet local policy targets. Although the service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- Main theatres did not always complete adequate assurance audits. Although the rest of the service had governance processes in place to monitor the quality of the services.

# Surgery

However:

- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well.
- Staff kept detailed records of patients' care.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.
- Ward staff identified and responded to changing patient risks, including deterioration. Staff were confident to seek additional support from senior staff if required.
- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.
- Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Managers monitored the effectiveness of care and treatment although there was limited evidence that they use them to improve service.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment.
- The trust planned and provided services in a way that met the needs of local people.
- The service took account of patients' individual needs.
- Managers at all levels in the division had the right skills and abilities to run a service and were sighted on improving the quality and safety of care.
- Surgery had a vision for what it wanted to achieve and workable plans to turn it into action.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

# Surgery

- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- Surgery was committed to improving services by learning from when things went well, promoting training, research and innovation.

## Is the service safe?

**Requires improvement**   

Our rating of safe stayed the same. We rated it as requires improvement because:

- Staff did not always complete mandatory training in line with the trust's target. Medical staff had not completed any mandatory training modules to in line with the trust's target.
- Medical staff did not always complete training to recognise and safeguard patients from abuse. However, nursing staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff in main theatres did not always fully complete the debrief section of the World Health Organisation (WHO) and five steps to safer surgery checklist.
- The service did not always have enough nursing staff to keep people safe from avoidable harm and to provide the right care and treatment.
- Patients did not always receive their medication at the right time. However, the service followed best practice when prescribing, recording and storing medicines.

However:

- The service, controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- Ward staff identified and responded to changing patient risks, including deterioration. Staff were confident to seek additional support from senior staff if required.
- The service had suitable premises and equipment and looked after them well.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

## Is the service effective?

**Good**  

# Surgery

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

- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.
- Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Managers monitored the effectiveness of care and treatment although there was limited evidence that they use them to improve service.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

However:

- Staff did not always complete training in relation to Mental Capacity Act and deprivation of liberty safeguards. Although staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

## Is the service caring?

**Good**   

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment.

## Is the service responsive?

**Requires improvement**   

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

- People could not always access the service when they needed it. Waiting times from referral to treatment performance had deteriorated since our last inspection in 2018 in respect of plastic surgery, general surgery and orthopaedic surgery.
- The timeliness of complaint responses did not meet local policy targets. Although the service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

However:

- The trust planned and provided services in a way that met the needs of local people.



# Surgery

- The service took account of patients' individual needs.

## Is the service well-led?

Good  

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

- Managers at all levels in the division had the right skills and abilities to run a service and were sighted on improving the quality and safety of care.
- Surgery had a vision for what it wanted to achieve and workable plans to turn it into action.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- Surgery was committed to improving services by learning from when things went well, promoting training, research and innovation.

However:

- Managers had not detected or acted upon issues related to the World Health Organisation (WHO) and five steps to safer surgery checklist. There had been no improvement in the quality audits in main theatres which meant data produced as a result was insufficient to effectively monitor performance. The service had failed to respond to previous concerns raised and had not ensured that oversight was effective to monitor and ensure improvements occurred.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Maternity

Requires improvement  

## Key facts and figures

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 across the three counties.

The trust's midwives and doctors will support women using their services to make informed decisions about place of birth, whether this is at home, in a midwifery unit or in an obstetric unit, after full discussion of the benefits and risks associated with each option.

The maternity service includes antenatal clinics at both Queen Elizabeth Hospital and North Cambridgeshire Hospital at Wisbech, and an antenatal day assessment unit at Queen Elizabeth Hospital. Waterlily birth centre, central delivery suite and a combined ante and postnatal ward are at the Queen Elizabeth site.

The four community midwifery teams provide a home birth service, parenting classes, hypnobirthing and postdate aromatherapy clinics. The choice of a pool labour or birth is available in both the midwife-led unit and the delivery suite. The service has a better than national average normal birth rate and homebirth rate.

*(Source: Trust Provider Information Request – Acute sites)*

From July 2017 to June 2018 there were 2,108 births at the trust.

We inspected this service as part of an announced inspection (they knew we were coming) between 5 to 7 March 2019. As part of this inspection we followed up and reviewed progress in relation to our previous enforcement, taken following our inspections in 2018. We found that the service had failed to ensure that all appropriate actions were taken or that action that had been implemented had been fully maintained. Further improvement was required and both regulatory actions remain in place to enable the improvement of safety within the service.

On 19 July 2018, CQC had issued an urgent notice of decision to impose conditions, under Section 31 of the Health and Social Care Act, 2008, These conditions set out ten specific actions to enable improvement in the maternity and midwifery service. We found that two of the ten conditions stated in the Section 31 had not been sustained and stated timeline not met. The trust responded appropriately to our concern and a plan for compliance was provided.

Following the focused inspection of maternity services in December 2018, we issued a requirement notice under Regulation 17 Health and Social Care Act (RA) Regulations 2014 Good governance. We found no notable improvement during this inspection in relation to governance and this was further supported by the failure to have clear oversight and monitoring of the Section 31 conditions.

During the inspection we visited the antenatal clinic (Brancaster ward), the day assessment unit (3 beds), the antenatal/postnatal ward (Castleacre, 24 beds), delivery suite (12 beds), Waterlily birthing suite (3 beds) and maternity theatres.

We spoke with 88 members of staff including ward clerks, maternity support workers, housekeeping staff, student midwives, midwives and obstetricians of varying grades, midwifery matrons, the practice development midwife, specialist midwives including the bereavement midwife and the antenatal screening midwife, the interim director of midwifery and the interim associate director of operations. We spoke with 6 women who were currently using the service and five of their relatives. We reviewed 11 care records and ten prescription charts.

# Maternity

## Summary of this service

Our rating of this service improved. We rated it as requires improvement because:

- There had been limited improvement with mandatory training compliance. Mandatory training rates were below trust targets for both nursing and medical staff. For example, medical staff compliance with adult basic life support was 52.4%.
- Safeguarding training compliance remained significantly under target, with only 46.2% of nursing staff compliant with safeguarding children level 3.
- Leaders had failed to ensure that compliance with previous enforcement had been completed and sustained which meant a potential risk to patient safety. The 100% compliance rate for training and competence for all appropriate staff reviewing, interpreting and classifying Cardiotocography (CTG) traces, had dropped. Not all policies and procedures had been updated to reflect current national guidance in the timeframe stipulated.
- Staffing vacancies were covered by bank and agency staff. Whilst there was a procedure in place to ensure that agency midwives had received suitable training, were competent to care for women and their babies and that swipe card access to the unit was monitored staff were unaware of this. We found there was no formalised process to record the return of swipe cards. We raised our concern on site and action was taken to review the process.
- Leadership stability remained fragile with several of the positions still filled by locum or interim staff.
- There remained no formal vision or strategy in place. The risk management strategy was still under review and had not progressed since December 2018.
- Governance, risk, and quality performance processes needed to embed to sustain and drive the initial improvements seen during our focused inspection in December 2018. Oversight of previous actions and improvements was not robust and internal processes had failed to identify where performance had dropped, and action was required.
- The multiple changes in leaders and the uncertainty brought with interim positions meant staff were unclear as to the future direction of the service. This meant a risk to the improved culture, which remained tentative. Not all staff felt engaged or that communication was open.

However:

- The improvement in completion of records and risk assessments for all women and babies had been maintained. Safety incidents continued to be reported and monitored appropriately.
- Staff training had increased in many areas since our last two inspections facilitating staff to provide improved care and treatment for the women and their babies in the department. Simulation training was utilised to facilitate this.
- There was good multi-disciplinary team work across all areas of the service to provide women with a choice of evidence based care which kept the women and their babies at the focus of care delivery.
- Staff working within the service supported women to make decisions regarding their care and treatment and place of birth. Staff cared for women and their families with compassion.
- Staff that we spoke with were proud to work for this service and were increasingly proud of the standards of care that they were providing. There was an increasingly supportive culture in which staff were supported to develop both themselves and the service provision to women and their babies.

# Maternity

## Is the service safe?

**Requires improvement**  

Our rating of safe improved. We rated it as requires improvement because:

- Some mandatory training rates such as obstetric emergencies and trust training did not meet trust targets.
- Safeguarding training rates were considerably lower than trust targets.
- The department had midwifery vacancies which meant that some clinical areas were short staffed at times. However, the service used bank and agency staffing to help mitigate the impact to care provision.
- Staff were not aware of the procedure in place to ensure that agency midwives had received suitable training, were competent to care for women and their babies and that swipe card access to the unit was monitored. Therefore, we were not assured that the procedure was implemented at all times.

However:

- The service controlled infection risks well. Staff kept themselves, all equipment and all premises clean.
- The department had suitable premises and equipment for good and safe maternity care provision.
- Staff completed appropriate records and risk assessments for all women and babies being cared for in their department and were available for all staff providing care.
- The service prescribed, administered, recorded and stored medicines well. Women and babies received the correct medication at the right time.
- The service managed safety incidents well. Staff recognised incidents and reported them accordingly. Managers investigated incidents and shared lessons learned with the whole team.

## Is the service effective?

**Good**  

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

- The service provided care and treatment based on national guidance. Action had taken place to update the majority of policies and procedures in line with current national guidance.
- The service carried out audits and evaluations to ensure both the compliance and the effectiveness of care provision and to benchmark their performance and highlight areas for improvement.
- At the time of inspection, the service was working towards the full implementation of the five elements of the Saving Babies' Lives Care Bundle (SBLCBv2), published in March 2019.
- The improved communication, engagement and multidisciplinary working seen in the December 2018 focused inspection had continued. Wider multidisciplinary working with external organisations had been implemented.
- Staff gave women and babies sufficient nutrition and hydration to meet their needs and wishes. The service made adjustments for religious, cultural and other preferences.
- Staff managed pain well. Women had access to a variety of analgesia and were able to self-administer medications.

# Maternity

- Maternity services were available to women seven days per week. Midwifery, obstetric and anaesthetic cover was provided outside of normal working hours.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support women experiencing mental ill health and implemented individualised care plans when needed.

However:

- The number of midwives and doctors whom had received training to be competent in identifying small for gestational age babies was low.
- At the time of inspection, not all policies and procedures had been updated to reflect current national guidance. We were shown a short timeline to address this alongside a longer term, three year forward plan, that had been developed to ensure that, moving forward, all guidelines would be reviewed in a timely manner.

## Is the service caring?

Good  → ←

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for women and their families with compassion. Feedback and observations confirmed that staff treated well, with kindness and compassion.
- Women described care from maternity staff with comments such as “cannot fault the midwives” “everyone has been fantastic” and “very happy with the hospital, chose this one (hospital) over another.”
- Staff provided emotional support to women and their partners to minimise their distress.
- Staff involved women and those close to them in decisions about their care and treatment.
- We observed staff interacting positively with women and those close to them.

## Is the service responsive?

Good  ↑ ↑

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

- The service planned and provided services to meet the needs and wishes of its service users. Services were provided to reflect the needs of the local population such as specialist clinics.
- Women could access the service mostly when they needed and wanted to. There was a triage service that was open 24 hours per day, seven days per week.
- The service took account of peoples’ individual needs. The service worked with external agencies to provide tailored care to women such as pregnant teenagers.
- The service treated complaints and concerns seriously, investigated them and shared the lessons learnt with staff and, if appropriate, made changes to practice to improve care provision.

# Maternity

## Is the service well-led?

**Requires improvement**  

Our rating of well-led improved. We rated well led as requires improvement because:

- Initial improvements in stability of leadership and improved culture, seen at the focused inspection in December 2018, had been sustained but remained fragile. There had been limited impetus to drive improvement further.
- Several of the senior leadership roles remained locum or interim posts.
- There remained no formal vision or strategy in place. The risk management strategy was still under review and had not progressed since December 2018.
- Governance processes needed to continue to improve. Changes had taken place but were yet to be fully achieved and sustained. Oversight of previous actions and improvements was not robust to ensure improvements were sustained.
- We were not assured that risk and quality performance processes were embedded, or fully effective to ensure improvements were ongoing, sustained and driven forward. The service had failed to ensure compliance in relation to previous enforcement action.
- Whilst there appeared to be continued improvement in culture in the unit, staff felt uncertain about their future direction due to differing leaders. There was a lack of effective communication to staff about changes taking place or planned in the unit.
- Whilst some staff felt that engagement with them was improving, it appeared to fall short in several areas.

However:

- The service collected, analysed, managed and used information to support all of its activities.
- The service was committed to improving services by learning from when things went well and when they went wrong, promoting training, audit and evaluation

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.



**Requires improvement**



## Key facts and figures

The trust provides gynaecology services to the populations of West Norfolk, East Cambridgeshire and South Lincolnshire. Gynaecology outpatient services are provided in Kings Lynn and Wisbech.

Outpatient gynaecology services are provided in the gynaecology diagnostic and outpatient treatment unit. Outpatient services include an early pregnancy assessment unit, general gynaecology outpatient clinics, urogynaecology, urodynamics, colposcopy and hysteroscopy clinics. In addition, hospital based services include cervical screening programme, gynaecology-oncology and nurse-led urogynaecology.

The gynaecology service does not provide a full termination of pregnancy service. However, termination of pregnancy is provided for women following a diagnosis of a fetal abnormality by an obstetrician and cared for by the surgical nursing team with oversight from the maternity team.

During the inspection, we visited four wards, outpatient's department and the early pregnancy unit. We spoke with 16 members of staff including consultants, clinical educators, specialist nurses, registered nurses, health care assistants and administrative staff. We spoke with four patients and three relatives. During our inspection, we observed episodes of care and reviewed five sets of patient records and five medication charts.

The team is involved in the MDT meetings within the specialities. There is no dedicated inpatient gynaecology ward, patients needing admission to an inpatient bed are admitted from the emergency department or from Appleton unit (Early Pregnancy Antenatal Unit). These patients are transferred to the surgical admissions unit, reviewed by the medical team and admitted to the appropriate ward. Admission for theatre is accessed through the day surgery unit, Marham ward (elective ward) or the surgical extended recovery unit, with the patients in these areas reviewed daily by the gynaecology medical team.

There is a ring-fenced side room on Elm ward for emergency gynaecology patients booked through a planned pathway.

This is the services first inspection as a core service, it had previously been inspected as part of the maternity service. The trust was unable to provide a breakdown of data specifically for gynaecology; most of the data provided related to both obstetrics and gynaecology.

During our inspection we visited the outpatient department, four inpatient surgical wards, main and day stay operating theatres.

We spoke with 16 members of staff including consultants, clinical educators, specialist nurses, registered nurses, health care assistants and administrative staff. We spoke with four patients and three relatives. During our inspection, we observed episodes of care and reviewed five sets of patient records and five medication charts. We found some significant concerns relating to follow up appointments.

Following the core service inspection, we undertook enforcement action and told the trust it must take action to improve. We issued an urgent notice of decision, under Section 31 of the Health and Social Care Act 2008, on the 18 March 2019. The notice imposed conditions on the trust registration and set out specific actions to enable the improvement of safety within the service. The trust must ensure there is an effective system in place to monitor and follow up patients within the gynae/oncology service post surgery, review or investigations.

# Gynaecology

## Summary of this service

We rated the service as requires improvement because:

- Staff did not always complete mandatory training in line with the trust's target. The trust target was not met for any of the seven mandatory training modules for qualified nursing and midwifery staff in gynaecology. The module manual handling had the lowest compliance rate of 33% below the trust target of 95%.
- Medical staff had not completed any mandatory training modules in line with the trust's target. The trust target was not met for any of the eight mandatory training modules for medical staff in gynaecology. The module adult basic life support had the lowest completion rate of 52% which did not meet the trust target of 95%.
- The service utilised a high number of locum medical staff and we were not assured that all staff had the appropriate training. The trust was unable to confirm that all medical staff had the relevant ultrasound scanning competency.
- Not all nurses had the appropriate competencies in place to provide the right care and treatment. Nurses did not hold a recognised post qualification gynaecological course. Whilst competencies were in place the assessor had not completed their own competencies. However, there was access to clinical nurse specialists and midwives for advice and support.
- The service did not routinely audit the effectiveness of care and treatment and use the findings to improve them. The service did not participate in Royal College of Gynaecology Safer Standards national audits.
- People could not always access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with good practice.
- The timeliness of complaint responses did not meet local policy targets. Although the service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- Leaders of the service did not always act on concerns raised in a timely manner. Staff did not feel empowered to improve the quality of care. Staff felt that they would escalate concerns, but no action would be taken.

However:

- There were systems and processes in place to monitor standards of cleanliness and hygiene. These included up to date policies, cleaning schedules and checklists, infection prevention and control training.
- There were systems and processes in place for medicine management concerning handling, storage and security of medicines. Staff kept medicines securely in the clinical areas we visited.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. The service took account of patients' needs.

# Gynaecology

## Is the service safe?

**Requires improvement**



We rated safe as requires improvement because:

- Mandatory training compliance rates did not meet the trusts set target. Completion rates for certain courses were particularly low, especially for medical staff. Compliance for adult basic life support 52% and medicine management 68% for medical staff, whilst manual handling for nursing staff was 33%.
- Not all areas controlled infection well. The dirty utility room in the outpatient's department had several boxes and old equipment storage cases on the floor, behind these obstructions the floor was dirty and dusty.
- The early pregnancy antenatal unit did not have the appropriate facilities to provide safe care and treatment as identified in the previous inspection. The unit had no emergency call bells or oxygen and portable suction equipment. This was mitigated in part as staff could access assistance and equipment from the maternity outpatient clinic which was next door.
- The service utilised a high number of locum medical staff and we were not assured that all staff had the appropriate training. The trust was unable to confirm that all medical staff had the relevant ultrasound scanning competency.
- Not all nurses had the appropriate competencies in place to provide the right care and treatment. Nurses did not hold a recognised post qualification gynaecological course. Whilst competencies were in place the assessor had not completed their own competencies. However, there was access to clinical nurse specialists and midwives for advice and support.
- Staffing in the early pregnancy unit was limited and did not always meet the appropriate levels to ensure patient safety at all times. Between January 2019 and February 2019, 50% of shifts (11 out of 22) were staff with one member of staff. Should a patient deteriorate there was a risk of a delay in summoning help.

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- There were systems and processes in place for medicine management concerning handling, storage and security of medicines. Staff kept medicines securely in the clinical areas we visited.

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

## Is the service effective?

**Good**



We rated effective as good because:

- The care and treatment delivered was evidenced based and reflected national guidance. Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.
- Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

# Gynaecology

- Staff gave patients enough food and drink to meet their needs and improve their health. The trust had a food and drink strategy for 2018 to 2021 in place. The strategy sited the five Department of Health hospital food standards and gave direction and guidance to all hospital staff.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Seven-day medical support was provided. A dedicated obstetrics and gynaecology consultant provided on-call out of hours care.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

However:

- The service did not routinely audit the effectiveness of care and treatment and use the findings to improve them. The service did not participate in the Royal College of Gynaecology Safer Standards national audits.
- Whilst the service undertook a number of local audits, these were inconsistent and there was limited evidence of actions and learning from audit to effect change.
- Mental Capacity Act training for medical staff was poor, with a compliance rate of 43%.

## Is the service caring?

**Good** 

We rated caring as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress. Staff gave patients and those close to them help, emotional support and advice when they needed it.
- Staff involved patients and those close to them in decisions about their care and treatment.

## Is the service responsive?

**Requires improvement** 

We rated responsive as requires improvement because:

- People could not always access the service when they needed it. The trust's referral to treatment time (RTT) for incomplete pathways has been worse than the England overall performance. This meant that patients were waiting longer for appointments following referral from their General Practitioner
- During the inspection we raised concern that a significant number of patients, post clinical procedure or investigations, had not received follow up appointments. This meant a risk of delay in ongoing treatment and emotional distress to those waiting for results. There were 165 patients affected. The trust responded immediately and took steps to review all patients and arranged additional clinics to address the backlog by the end of April 2019.

# Gynaecology

- The timeliness of complaint responses did not meet local policy targets. The trust took an average of 38 working days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be completed within 30 working days.

However, we also found:

- The trust planned and provided services in a way that met the needs of local people. The service had clear systems in place to stream elective and emergency admissions. Patients on the emergency admissions pathway went to the surgical assessment unit prior to surgery and were transferred to a surgical ward following their procedure.
- The service took account of patients' individual needs. Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.
- Patients and relatives had access to the chaplaincy and bereavement services, and staff could access interpreting services when required.

## Is the service well-led?

**Requires improvement**



We rated well-led as requires improvement because:

- There was a triumvirate structure of leadership within the service with defined roles and responsibilities. However, gynaecology as a stand-alone service, from maternity, lacked clarity and definition. Whilst there was overlap of specialist nurses and medical staff with the maternity service a specific focus on gynaecology was inconsistent. Several of the senior leadership roles were locum or interim posts.
- Leaders of the service did not always act on concerns raised in a timely manner. Staff did not feel empowered to improve the quality of care. Staff felt that they would escalate concerns, but no action would be taken.
- The arrangement for governance and performance management were not fully clear and did not operate effectively. Managers had failed to escalate the backlog of patients who required a follow up appointment or medical review. National and local audit was not utilised effectively to improve services.
- Whilst there were systems in place to identify and manage risk these were not monitored effectively. We were not assured that the oversight of local risk was monitored appropriately. The Control of Substances Hazardous to Health (COSHH) risk registers were significantly out of date for review.
- The service did not have a local vision for what it wanted to achieve. Staff were not actively engaged in development of the service. There was minimal engagement with people who used services, relatives, the public or external partners.

However, we also found;

- Staff from the early pregnancy antenatal unit shared the most recent patient experience outpatient survey with the inspection team. From October 2018 to January 2019 the unit had received 25 comments. Patients comments included but were not limited to "kind, friendly, amazing, professional and reassuring staff ". Out of the 25 comments we reviewed 24 were very positive and one negative. One patient had found the location of the unit (near the maternity suite) very distressing.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Services for children and young people

Good   

## Key facts and figures

Rudham ward is the paediatric inpatient ward with 23 beds. Children up to 16 years, with medical conditions are cared for by the consultant paediatricians on the ward. Over 16, these young people are cared for by the medical division on adult medical wards. Children being admitted for surgical conditions are cared for on Rudham ward up to age 18.

The five-bed paediatric assessment unit (PAU) is located at the end of Rudham ward. The PAU is open from 9am to 9.30pm Monday to Friday and takes referrals from the emergency department (ED) and direct from GPs.

The trust's neonatal unit is commissioned for one intensive care, two high dependency and 12 special care baby cots. The team supports a four-bedded transitional care unit on the postnatal ward.

Paediatric outpatient services are delivered from Roxborough children's outpatient department.

The trust provides general paediatric clinics including management of asthma and specialist clinics for diabetes; oncology (level 1 shared care unit); cystic fibrosis; gynaecology (with a consultant gynaecologist); epilepsy, rheumatology (jointly with a consultant rheumatologist) and cardiology as well as additional services like physiotherapy and orthotics.

The trust had 3,856 admissions from August 2017 to July 2018. Emergency admissions accounted for 93% (3,581 admissions), 6% (230 admissions) were day case admissions, and the remaining 1% (45 admissions) were elective.

During our inspection we visited Rudham ward, the neonatal intensive care unit (NICU), Roxborough children's outpatient department (OPD), the paediatric assessment unit (PAU) and the surgical day unit (SDU).

We spoke with 25 registered children's nurses (RCN), eight doctors, six consultants, one play specialist, one secretary, 11 patients and 12 family members. We reviewed 17 patient medical records and five patient nursing records along with other relevant documentation such as meeting minutes and policies

## Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- The service provided mandatory training in key skills. Nursing staff mandatory training compliance was 90% on Rudham ward and 91% on NICU. Staff had safeguarding training and they knew how to recognise, and report abuse to protect patients.
- The service had suitable premises and equipment, looked after them and controlled infection risk well.
- Staff kept detailed records of patients' care and treatment, completed and updated risk assessments for each patient and followed best practice when prescribing, giving, recording and storing medicines. Care and treatment was based on national guidance.
- The service had enough nursing and medical staff with the right qualifications, skills, training and experience to keep people safe from harm and to provide the right care and treatment. Managers made sure staff were competent for their roles, appraised staff's work and performance. Staff of different specialities worked together as a team to benefit patients.

# Services for children and young people

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- Staff gave patients enough food and drink to meet their needs and improve their health. They assessed and monitored patients regularly to see if they were in pain and promoted good health.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care and understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff cared for patients with compassion, provided emotional support and involved patients and those close to them in decisions about their care.
- The trust planned and provided services in a way that met the needs of local people and took account of patients' individual needs. Waiting times from referral to treatment were in line with good practice.
- Managers at all levels in the service had the right skills and abilities to run a service providing care and they promoted a positive culture that supported and valued staff.
- The service had effective systems for identifying risks, collected, analysed, managed and used information well to support its activities and engaged with patients and staff to plan and manage appropriate services. The service treated concerns and complaints seriously.

However:

- Mandatory training compliance for medical staff did not meet trust target (90%) for any of the eight modules.
- Safeguarding children level three training compliance for nursing and medical staff did not meet trust target of 95%. Nursing was 89% and medical staff was 85%.
- The service did not have enough consultants to meet royal college of paediatric and child health (RCPCH) guidance and consultant handwriting was not always legible in all medical records.
- Not all nursing staff in NICU handed over care of the babies when leaving the nursery for an extended period of time and one member of nursing staff was heard to use discriminatory language when speaking about a patient with known mental health issues.
- Staff on Rudham ward did not have a portable telephone call so that they could make confidential calls in a private area away from the nurse's station.
- Governance structures were not embedded, not robust and did not give enough consideration to children and young people's services and did not monitor the progress of the CYP strategy which staff were unaware of.
- There was no representation of CYP services at the quality and safety committee meetings, mortality review meetings or the mental health governance committee meetings and the service did not have a CYP specific learning disability nurse.

## Is the service safe?

Good  → ←

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

- The service provided mandatory training in key skills to all staff and made sure staff completed it. nursing staff mandatory training compliance overall by ward was Rudham 90% and NICU 91%.



# Services for children and young people

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service controlled infection risk well. Staff kept equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well.
- Staff completed and updated risk assessments for each patient. They kept clear records of care and asked for support when necessary.
- The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- The service had enough doctors with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. The service did not have enough consultant grade staff but had taken mitigating action to keep people safe from avoidable harm and to provide safe care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were, on the whole, clear, up-to-date and easily available to all staff providing care.
- The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- Mandatory training compliance for medical staff did not meet trust target for compliance (90%) for any of the eight modules.
- Safeguarding children level three training compliance for nursing and medical staff did not meet trust target of 95%. Nursing was 89% and medical staff was 85%.
- The service did not have enough consultants in order that they could operate their shift pattern in line with royal college of paediatric and child health (RCPCH) guidance.
- Consultant handwriting was not always legible in all medical records.
- There was not always representation of the CYP service at mortality review meetings.
- Not all nursing staff in NICU handed over care of the babies when leaving the nursery for an extended period of time. This meant a potential risk to the safety of babies.
- Staff on Rudham ward did not have a portable telephone call so that they could make confidential calls in a private area away from the nurse's station.

## Is the service effective?

Good  ➡ ➡

Our rating of effective stayed the same. We rated it as outstanding because:

# Services for children and young people

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.
- Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- The service promoted health and wellbeing to children and young people.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- Staff of different specialities worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

However:

- One member of nursing staff was heard to use discriminatory language when speaking about a patient with known mental health issues.

## Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment.

## Is the service responsive?

Good   

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

- The trust planned and provided services in a way that met the needs of local people.

# Services for children and young people

- The service took account of patients' individual needs.
- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

However:

- The service did not have a CYP specific learning disability lead.

## Is the service well-led?

**Requires improvement**  

Our rating of well-led went down. We rated it as requires improvement because:

- The service did not monitor the progress of the CYP strategy and staff were unaware of it.
- Governance structures were not embedded, not robust and did not give enough consideration to children and young people's services. Not all levels of governance and management functioned effectively.
- The service had systems for identifying risks, planning to eliminate or reduce them, but these were not embedded. Poor performance was not always dealt with appropriately or quickly enough.
- The service leaders as a triumvirate had only met twice between June 2018 and January 2019. This meant inconsistent oversight of risks and issues. There had been no recent review of the governance arrangements, strategy or plan.
- There was no representation of CYP services at the mental health governance committee meetings or the quality and safety committee meetings.

However:

- Managers at local level in the service had the right skills and abilities to run a service providing care.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service collected, analysed, managed and used information to support its activities, using secure electronic systems with security safeguards.
- The service engaged with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# End of life care

Inadequate ● ↓

## Key facts and figures

End of life care throughout the hospital was supported by the specialist palliative end of life care (EoLC) team, which was consultant-led. The team consisted of two palliative clinical nurse specialists based at the trust who were supported by a palliative consultant based at a local hospice. The service provided care for patients who had complex needs and patients who were in their last days of life. The team also provided support and education to staff.

The multi-disciplinary team worked in collaboration with the local hospice, providing a 7-day service with face to face clinical nurse specialist visits on Monday to Friday 9am-5pm and 10am-2pm at weekends, and an on-call service available 9am-5pm at weekends. Outside of these hours there was a palliative medicine consultant on-call and 24-hour advice provided by end of life care (EoLC) professionals based at the local hospice. The local acute community trust provided holiday cover for the specialist nurses.

A palliative care multidisciplinary team (MDT) meeting took place every week. Close working with heart failure, chronic obstructive pulmonary disease (COPD), motor neurone disease (MND) and renal failure MDTs also supported identification, planning and communication for complex needs such as managing pain, psychological support and symptom control.

*(Source: Routine Provider Information Request (RPIR) – Context acute tab)*

The trust had 1,210 deaths from August 2017 to July 2018.

*(Source: Hospital Episode Statistics)*

We last inspected the end of life care service at this trust in 2018. We served a requirement notice in relation to end of life care. The issues that we raised were regarding do not attempt cardiopulmonary resuscitation (DNACPR) forms and the implementation of end of life care initiatives. At this inspection there was some improvement in the completion of DNACPR forms, however they were not always completed correctly. Some forms we reviewed indicated that the patient lacked capacity, however there was not a corresponding capacity assessment, or the capacity assessment was carried out days after completion of the DNACPR form. The implementation of end of life care initiatives came from the end of life care strategy. The individualised plan of care (IPOC) was one of those initiatives, and the issue remained that it was not widely used across the hospital and was not effectively used.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. We undertook our inspection of the end of life care service from 5 to 7 March 2019. We visited 10 wards at the trust, which included the oncology and palliative care ward, the stroke ward, older people's medicine wards and the emergency department. We also visited the mortuary and the hospital chapel.

We spoke with 50 members of staff, including medical and nursing staff, allied health professionals, the specialist palliative care team, the chief nurse, chaplaincy, mortuary and bereavement staff. We spoke to one patient who was receiving end of life care and three patients' relatives.

We reviewed 15 care records for patients receiving end of life care, 22 do not attempt cardiopulmonary resuscitation (DNACPR) records and 11 prescription charts throughout the inspection.

# End of life care

## Summary of this service

Our rating of this service went down. We rated it as inadequate because:

- The service did not have enough medical staff with the right mix of qualifications and skills to keep patients safe and provide the right care and treatment. Medical staffing was not in line with national guidance. This was raised at our last inspection.
- The individualised plan of care (IPOC) was not consistently used across the organisation and was therefore not embedded in practice. This had been raised as an issue during our last inspection in 2018 yet no improvement had been made.
- Completion of do not attempt cardio pulmonary resuscitation (DNACPR) forms was not consistently in line with Resuscitation Council UK guidelines. Despite this being raised at our previous inspection as a requirement notice where the trust must improve we found inconsistencies remained. An overall improvement of only 14% had been achieved.
- End of life patients were not always identified at an early stage to ensure adequate symptom control in a timely manner. This meant that patients did not receive the highest quality care that met their individual needs.
- There was no stable leadership team to support and promote end of life care. The service was over reliant on the end of life care facilitator and staff were unclear who was responsible for the service.
- Leaders did not demonstrate the right skills and abilities to deliver a high-quality service. There was a lack of ownership of end of life care from senior leaders. Staff we spoke to during our inspection were not aware of who the lead was for end of life care.
- The service monitored the effectiveness of care and treatment, but we did not always see evidence that they used the findings to improve the service. The trust took part in the National Audit for Care at the End of Life (NACEL). Results from the first round of this audit showed areas for improvement, however information provided by the trust stated that the results had not yet been presented to the board and we were not assured that any actions would be taken in the interim before the second round of the audit.
- The trust end of life strategy did not give definitive timescales or commitments to achieve its aims and service improvements, and staff we spoke with did not know what the strategy was.
- Staff told us that end of life care was not seen as a priority throughout the trust.
- There was a lack of oversight in ensuring that the end of life strategy was implemented, including the IPOC. The IPOC was not routinely used throughout the trust. Without it being used and audited, the trust did not have oversight of their performance in end of life care.
- We were not assured that issues were escalated appropriately and acted upon. In two sets of three end of life steering group meeting minutes that we reviewed it was documented that the issues to be escalated would be agreed outside of the meeting.
- The trust did not have effective systems for identifying risks throughout the service. We identified risks during our inspection that the trust had not identified as risks. Information provided by the trust stated that there were no risks for end of life care on the trust risk register.

# End of life care

- The trust did not hold data on how many referrals were made to the palliative care team. This prevented the trust from having oversight of the service and meant that we were not assured patients had access to the palliative care team when they needed it. This information was provided at our last inspection which meant there has been a reduction in oversight of the service.
- Data provided to demonstrate whether patients achieved their preferred place of death showed inconsistencies, and incorrect statements were attributed to some of the figures. Therefore, we could not be assured that the data presented was accurate.

However:

- Staff understood how to protect patients from abuse and knew who the trust safeguarding lead was and how to contact them. Staff were able to describe the safeguarding process.
- The service had enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.
- Staff from different disciplines worked together as a team to benefit patients, both within the trust and community services. A weekly multi-disciplinary team (MDT) meeting took place which included members of the hospital end of life care team as well as representatives from the local acute community trust and the local hospice.
- Staff cared for patients with compassion. Feedback from patients and relatives confirmed that staff treated them well.
- The service took account of patients' individual needs. Patients and relatives had access to the chaplaincy and bereavement services, and staff could access interpreting services when required.

## Is the service safe?

**Requires improvement**   

Our rating of safe stayed the same. We rated it as requires improvement because:

- Mandatory training completion rates did not always meet the trust target. Nursing staff met mandatory training targets for four out of seven modules, and medical staff met targets for five out of eight modules. The lowest completion rate was in infection prevention training.
- Records of patients' care and treatment were not always clear. Some records were disorganised, with some information not clearly ordered which made them difficult to review.
- Patient records were often not securely stored on the wards we visited. We saw the trolleys they were kept in left open on some wards.
- Patients receiving end of life care did not have individualised plans of care (IPOC) in place. We saw evidence of one IPOC being partially completed during our inspection, despite this being raised as an issue at our last inspection.
- The service did not have enough medical staff, with the right qualifications, skills and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Medical staffing was not in line with national guidance. This has declined since our last inspection as there was previously a specialty doctor in post.
- There were four cases out of 15 patient records where ceilings of treatment had not been documented. This meant that staff would not necessarily have known how to treat those patients if their condition deteriorated.
- We were not assured that all patient safety incidents were being captured and managed appropriately as the end of life group noted that not all incidents were categorised as end of life incidents that should have been.

# End of life care

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well. Equipment maintenance and service requirements were up to date.
- The service had enough nursing staff, with the right qualifications, skills and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- The service followed best practice when prescribing, giving and recording medicines. Patients received the right medication at the right dose at the right time.

## Is the service effective?

**Inadequate** ● → ←

Our rating of effective stayed the same. We rated it as inadequate because:

- The individualised plan of care (IPOC) was still not consistently used across the organisation and was therefore not embedded in practice. This was raised as an issue at our last inspection in 2018 and had not improved. The IPOC for the anticipated last days of life was recognised as a priority for care according to the Leadership Alliance for the Care of Dying People: A national framework for local action 2015-2020.
- Further improvement was required with the completion of do not attempt cardio pulmonary resuscitation (DNACPR) forms, to ensure the safety of patients. Inconsistencies remained in the completion of these forms which meant we were not assured the safety of patients who had DNACPR forms in place was consistently maintained.
- We were not assured that mental capacity assessments were always completed for people who had DNACPR forms in place.
- End of life patients were not always identified at an early stage to ensure adequate symptom control in a timely manner. This meant that not all patients received high quality care that met their individual needs.
- Mandatory training in the Mental Capacity Act was completed by 87.5% of staff in end of life care compared to a trust target of 95%.
- We did not always see evidence that the trust used findings to improve care provision. We were not assured the trust had oversight of DNACPR or could evidence that local audit was being used to effectively improve practice.
- Nursing staff did not receive sufficient formal supervision and instead arranged their own informal supervision.

However:

- Staff gave patients enough food and drink to meet their needs. They used special feeding and hydration techniques when necessary.
- Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.



# End of life care

- Doctors, nurses and other healthcare professionals worked together to deliver care and treatment in a multidisciplinary way. This included working with the local acute community trust and hospice provider.

## Is the service caring?

**Good**   

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients and their families confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients identified as end of life, and those close to them, in discussions about their care and treatment.

## Is the service responsive?

**Inadequate**   

Our rating of responsive went down. We rated it as inadequate because:

- Data provided to demonstrate whether patients achieved their preferred place of death showed inconsistencies, and incorrect statements were attributed to some of the figures. We also identified that some of the percentage calculations were incorrect. Therefore, we could not be assured that the data presented was accurate.
- Information provided by the trust stated that they did not monitor the number of referrals to the specialist palliative care team, or the percentage of referrals that were seen within 24 hours, because this data was held by the local acute community trust. The trust provided this information at the time of our previous inspection, therefore there has been a reduction in oversight of the service.
- We could not be assured that the trust met peoples' needs through the way services were organised and delivered. We could not be assured that the service was meeting the needs of patients or identifying unmet needs and using that information to improve and develop services.
- The trust was unable to provide data to assure us that waiting times from referral to treatment were in line with good practice. This meant we were not assured patients had access to the specialist palliative care team when they needed it.

However:

- The service took account of patients' individual needs once identified as end of life. Patients and relatives had access to the chaplaincy and bereavement services, and staff could access interpreting services when required.
- The service treated complaints and concerns seriously, investigated them and learned lessons from the results, and shared these with staff.

## Is the service well-led?

**Inadequate**  

# End of life care

Our rating of well-led went down. We rated it as inadequate because:

- Leaders did not have the necessary knowledge and capacity to deliver a high-quality service. There was a lack of ownership of end of life care from senior leaders. Staff we spoke to during our inspection were not aware of who the lead was for end of life care.
- There was no effective strategy in place for end of life care. There had been no improvement in the development or engagement of the strategy. Staff we spoke to, including senior staff, could not describe what the end of life care strategy was. Part of the strategy included that staff would be trained in using the individualised plan of care (IPOC) which was not embedded within the trust. This was a long-standing issue as we raised it at our last inspection in 2018.
- Data provided to demonstrate key performance metrics, such as whether patients achieved their preferred place of death, was inaccurate. We could not be assured of the validity or reliability of information that was being utilised to monitor the service.
- The end of life group did not have oversight of service performance as they did not have access to information about the number of referrals to the specialist palliative care team or the number of referrals that were responded to within 24 hours.
- There was a lack of governance and oversight of risks and issues, and limited measures for quality improvement. We were not assured that issues were escalated appropriately, and the trust did not have oversight of their performance in end of life care. Mandatory training compliance was poor, local audit was not effectively utilised to effectively improve practice and the IPOC was not embedded. Not all patients received person centred care that met their needs.
- The trust did not have effective systems for identifying risks throughout the service. We identified risks during our inspection, however the trust told us that there were no risks for end of life care on the trust risk register.
- From the data we reviewed, there was no specialist palliative care input at the mortality and morbidity meetings. This was a concern raised at our previous inspection and there does not appear to have been any improvement from the minutes that were made available to us.
- We saw evidence of teams working in silos to provide end of life care, and while they included positive initiatives, they were not coordinated trust wide approaches. Staff felt end of life care was not considered to be a priority within the trust.
- Many of our current concerns were raised in our previous inspection report published in September 2018. Despite this, there has been minimal improvement with many areas for concern remaining unchanged.

However:

- The trust sought to improve engagement with patients, relatives and staff.
- The mortuary service held their own comprehensive risk register.
- The trust introduced a blue ribbon scheme to identify patients whose best interests were to remain on the ward they were already on to avoid unnecessary distress to patients and relatives.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Outpatients

Requires improvement   

## Key facts and figures

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust provides outpatient services to a local population, predominantly from West Norfolk and parts of Breckland, Cambridgeshire and South Lincolnshire. Outpatient services include: ophthalmology; ear, nose and throat (ENT); dental and oral surgery; trauma and orthopaedics; pain; rheumatology; stroke clinics; elderly care; haematology/oncology; breast care; therapy services; audiology; podiatry; and paediatrics.

Outpatient services are mainly provided from The Queen Elizabeth Hospital, with some specialist services and clinics provided in community facilities, such as North Cambridgeshire hospital in Wisbech and St Georges Medical Centre in Littleport.

Outpatient clinics are supported by multidisciplinary teams including registered nurses, nurse specialists and allied health professionals.

From August 2017 to July 2018, the trust had 296,245 outpatient appointments.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. We undertook our inspection of the outpatient department from 5 to 7 March 2019.

During this inspection, we visited main outpatients, ear nose and throat (ENT) clinic, trauma and orthopaedic clinic, the plaster room, the breast unit, dermatology, dental clinics and diabetic clinic. We spoke with nine patients, one relative and 34 members of staff including medical and nursing staff, healthcare assistants, therapy, domestic staff and volunteers. We observed care and looked at five sets of medical records. We also looked at a wide range of documents including policies, standard operating procedures, meeting minutes, action plans, prescription charts, risk assessments and audit results. Before our inspection, we reviewed performance information from April 2018 to December 2018 about the trust.

## Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- Although the service had suitable premises and equipment in most areas and looked after them well some areas did not meet the needs of the service. For example, the diabetic clinic consulting room. This impacted on staff being able to protect patient's privacy and dignity when delivering care.
- Outpatient areas did not routinely audit the effectiveness of care and treatment and use the findings to improve them. This had not improved since the previous inspection.
- Non-admitted referral to treatment pathway rates were below the trust's operational standard and the England average. This meant that patients were waiting longer for appointments after being referred by their GP.
- The trust did not routinely collect data on late starting clinics or patient waits in outpatients. Main outpatients had begun to collect this data but had yet to analyse the information collected.
- Car parking facilities did not always meet demand. Patients reported that they often had difficulty parking when attending for clinic appointments which caused them to be concerned that they would miss their appointment.

# Outpatients

- The outpatient's department did not have a local vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- We were not assured that local risk and performance was monitored appropriately. There was a lack of robust monitoring of referral to treatment times and control audits across all areas of outpatients.
- The trust did not have processes in place to engage with patients, the general public and local organisations to plan and manage appropriate services. Staff were positive about engagement with local managers but reported that engagement with the trust senior executive team was inconsistent.
- There were processes and systems of accountability within clinical business units although these were not always effective. Outpatients were split over a number of different business units. There did not appear to be oversight and shared learning across all outpatient areas.

However:

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
- The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- The service took account of patients' individual needs.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. The average time to investigate and close complaints was \*\*. This had improved since the previous inspection
- The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.
- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

# Outpatients

## Is the service safe?

**Good**   

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

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection. This had improved since the previous inspection.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
- The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

However:

- The service provided mandatory training in key skills to all staff. However, managers reported that at times face to face training courses were cancelled which impacted staff training compliance.

## Is the service effective?

**Not sufficient evidence to rate** 

We do not rate effective. We found the following areas of good practice:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance. This had improved since the last inspection.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

However:

# Outpatients

- Outpatient areas did not routinely audit the effectiveness of care and treatment and use the findings to improve them. This had not improved since the previous inspection.

## Is the service caring?

**Good**   

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff provided emotional support to patients to minimise their distress.

However:

- Although staff worked to ensure that patient's privacy and dignity were protected when providing care, the environment did not always make this possible. For example, in the diabetic clinic patients were seen in a room that also acted as a storage cupboard meaning staff accessed the room to collect supplies.

## Is the service responsive?

**Requires improvement**   

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

- The trust's referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance. This meant that patients were waiting longer for appointments after being referred by their GP.
- There were 6374 patients on the backlog list awaiting a follow up appointment, with the longest overdue waits within urology, gastroenterology and ophthalmology. There were processes in place to ensure that patients were safe to wait.
- Between August 2018 and February 2019, the total of 866 clinics were cancelled. Of these 537 were cancelled with a notification of 6 weeks or under (62%). Reasons given for cancellation were staff annual leave, study leave, doctor on call, staff shortages, sick leave, and meetings.
- The trust did not routinely collect data on late starting clinics or patient waits in outpatients. Main outpatients had begun to collect this data but had yet to analyse the information collected.
- Car parking facilities did not always meet demand. Some patients told us that they regularly had difficulty finding parking when visiting the hospital for clinic appointments.
- Not all areas had suitable premises and equipment to meet the needs of the service, for example the diabetic clinic consulting room, where patients were seen, was utilised as a storage room.

However:

- The trust is performing better than the 96% operational standard and similar to the England average for patients waiting less than 31 days before receiving their first treatment following a diagnosis

# Outpatients

- The trust planned and provided services in a way that reflected the needs of local people offering flexibility, choice and continuity of care.
- The service took account of patients' individual needs.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. The average time to investigate and close complaints was 31 days against a trust target of 30 days. This had improved since the previous inspection.

## Is the service well-led?

**Requires improvement** ● ➡ ➡

Our rating of well-led stayed the same. We rated it as requires improvement because:

- There were processes and systems of accountability within clinical business units although these were not always effective. Outpatients were split over a number of different business units. There did not appear to be oversight and shared learning across all outpatient areas.
- We were not assured that local risk and performance was monitored appropriately. There was a lack of robust monitoring of referral to treatment times and control audits across all areas of outpatients.
- There was a lack of recorded action plans to address concerns such as the referral to treatment times (RTT) and follow up backlog. It was unclear what actions for quality improvement had been put in place and how these were being monitored.
- The trust did not have processes in place to engage with patients, the general public and local organisations to plan and manage appropriate services. Staff were positive about engagement with local managers but reported that engagement with the trust senior executive team was inconsistent.
- The outpatient's department did not have a local vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

However:

- The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.
- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

The service was committed to improving services by learning from when things go well and when they go wrong and promoting training.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.



# Diagnostic imaging

## Key facts and figures

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust provides diagnostic imaging services to a local population, predominantly from West Norfolk, parts of Breckland, Cambridgeshire and South Lincolnshire. Diagnostic imaging services include: plain film, computed tomography (CT), magnetic resonance (MRI), ultrasound, nuclear medicine and fluoroscopy.

Diagnostic imaging services are mainly provided from Queen Elizabeth Hospital King's Lynn, with a limited plain film and ultrasound service at Swaffham Community Hospital and also at North Cambridgeshire Hospital.

The diagnostic imaging service is supported by a multidisciplinary team, including; consultant radiologists, specialist registrars, radiographers, sonographers, radiology support workers and administration support.

The service reported that from January to December 2018 their total activity was 147, 622 examinations.

During this inspection, we visited plain film x-ray, CT, MRI, nuclear medicine and ultrasound departments. We spoke with five patients, 37 members of staff including consultants, radiographers, sonographers, radiology support workers, administrators, service managers and an engineer. We observed staff providing patient care. We also looked at a wide range of documents including policies, standard operating procedures, meeting minutes and performance management information.

We undertook further enforcement action following the inspection of diagnostic imaging, in April 2019, where we found significant concerns and risks to patients. We issued an urgent notice of decision, under Section 31 of the Health and Social Care Act 2008, on the 16 May 2019, to impose conditions on the trust registration as a service provider in respect of the regulated activity: Diagnostic and Screening Procedures. These conditions set out specific actions to enable the improvement of safety within the service.

We then served a warning notice, on the 23 May 2019, under Section 29A of the Health and Social Care Act 2008. This identified specific areas that the trust must improve and set a date for compliance as 30 June 2019.

## Summary of this service

Our rating of this service went down. We rated it as inadequate because:

- The service did not manage patient safety incidents well. Staff did not recognise incidents or report them. Managers did not share lessons learned effectively with local team and the wider service.
- The service provided mandatory training in key skills to staff but did not ensure that everyone completed it. Mandatory training compliance rate for the service was 70% below the trust target of 95%. Basic life support training which included anaphylaxis response was 41%.
- Staff were unclear about their understanding and responsibilities when administering contrast media to patients.
- Staff were unclear as to how findings from a diagnostic image which the reporting clinical specialist had concerns were significant and required further investigation, were escalated to ensure that patients received timely and appropriate care. The service did not have enough staff with the right qualifications, skills, training and experience in all areas to provide the right care and treatment.
- The service had not ensured that policies and procedures were in place across the diagnostic imaging department.

# Diagnostic imaging

- This system to staff the out of hours service was not sustainable and presented a risk to the delivery of a robust and safe service to patients.
- Most staff of different kinds worked together as a team to benefit patients. However, three radiographers told us that they felt bullied by some doctors from the emergency department out of hours, when the doctors wanted a scan performed on a patient.
- Lessons learnt from complaints were not shared with staff.
- The service did not have managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.
- Morale amongst staff was low. Staff felt there was a disconnect between themselves and managers. Staff did not feel supported and valued. There was not a sense of common purpose based on shared values.
- The service did not have effective systems for identifying risks, planning to eliminate or reduce them.
- The service did not engage well with staff to plan and manage appropriate services.

However:

- The service had suitable premises and equipment and looked after them well.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- The service took account of patients' individual needs.

## Is the service safe?

**Inadequate** ● ↓

Our rating of safe went down. We rated it as inadequate because:

- The service did not manage patient safety incidents well. Staff did not recognise incidents or report them. Managers did not share lessons learned effectively with local team and the wider service. Following three serious incidents involving radiology, staff were unclear about actions following the initial investigations. Sharing of information was inconsistent and oversight of changes of practice to ensure patient safety was not apparent.
- Staff in the service did not follow best practice to manage infection risk well. Staff did not always wear appropriate personal protective equipment when delivering care.
- The service provided mandatory training in key skills to staff but did not ensure that everyone completed it. Mandatory training compliance rate for the service was 70% below the trust target of 95%. Basic life support training which included anaphylaxis response was 41%. Therefore, we were not assured that all staff had the right skills and training to provide care to a patient in an emergency.

# Diagnostic imaging

- Staff were unclear about their understanding and responsibilities when administering contrast media to patients. Although staff were aware that patients required blood test prior to having contrast media there was no clear guidance regarding process when patient blood results were a contraindication for the patient to have contrast media. Staff gave inconsistent responses as to what they should do when this occurred.
- Staff were unclear as to how findings from a diagnostic image which the reporting clinical specialist had concerns were significant and required further investigation, were escalated to ensure that patients received timely and appropriate care. Of the four members of staff we asked none could explain the process. Staff were unclear if there was a policy or guideline in place.
- The service did not have enough staff with the right qualifications, skills, training and experience in all areas to provide the right care and treatment. Three consultant radiologist posts were un-filled and three sonographer posts were unfilled. Managers told us that there had not been a review of staffing establishment despite an increase in demand for diagnostic imaging.
- Staff did not follow processes when administering contrast media to children. Contrast media was administered to adult patients using a patient group direction (PGD). PGDs allow the supply and administration of medicines to patients by certain registered healthcare professionals, without a prescription or reference to a prescriber. The PGD had inclusion and exclusion criteria and children under the age of 18 were not covered by the PGD. Radiographers were routinely working out side of the PGD and administering contrast to children.

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service planned for emergencies and staff understood their roles if one should happen.

## Is the service effective?

**Not sufficient evidence to rate**



We do not rate effective. We found the following:

- The service had not ensured that policies and procedures were in place across the diagnostic imaging department. There was a lack of key guidance and protocols for staff to use. Not all staff were aware of policies and procedures that were in place within diagnostic imaging and did not routinely use them in their practice. We found several policies that were out of date and due for review.
- The service did not ensure staff were competent for their roles. The service appraisal rate was 70% and not all staff had their performance appraised.
- This system to staff the out of hours service was not effective or sustainable. Radiography staff covered night and weekend via a rostered voluntary bank system. Staff told us that they felt that they were working long hours to cover the out of hours service. They told us that they felt pressured to work as they did not want to let their colleagues and patients down.
- Most staff of different kinds worked together as a team to benefit patients and Doctors, allied health care professionals, support staff and administration healthcare professionals supported each other to provide good care. However, three radiographers told us that they felt bullied by some doctors from the emergency department out of hours, when the doctors wanted a scan performed on a patient.

However:

# Diagnostic imaging

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- The service had obtained ISAS accreditation (imaging services accreditation scheme). Services included under the accreditation are radiography, ultrasound, mammography, CT, MRI, PACS and teleradiology.

## Is the service caring?

**Good**   

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff provided emotional support to patients to minimise their distress.

## Is the service responsive?

**Requires improvement**   

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

- There was no effective process in place for the service to monitor nonattendance rates.
- Information around report turnaround times were not presented in a way that provided assurance that data was used to improve the service for patients.
- Patients could not always access the service when required. Weekend and evening appointments were offered to patients in MRI and CT, but this was limited due to staff capacity. Staff told us that on occasion evening lists had to be cancelled due to lack of staff to cover the list.
- The service did not utilise findings from complaints to improve services. Lessons learnt from complaints were not shared with staff effectively.

However:

- The services provided reflected the needs of the population served and generally ensured some flexibility, choice and continuity of care.
- The service took account of patients' individual needs.

## Is the service well-led?

**Inadequate**  

Our rating of well-led went down. We rated it as inadequate because:

# Diagnostic imaging

- The service did not have managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. All staff we spoke to felt that there was not effective communication between the management team and staff. They told us that although some leaders were approachable they felt that others were not and did not feel comfortable to raise concerns and that their concerns were not addressed.
- The service did not have a vision for what it wanted to achieve or a workable plan to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- Morale amongst staff was low. Staff felt there was a disconnect between themselves and managers. Staff did not feel supported and valued. There was not a sense of common purpose based on shared values.
- The service did not have effective systems for identifying risks, planning to eliminate or reduce them. Risks and issues and were not identified and escalated. There was not a holistic approach to monitoring safety performance and quality to identify and share learning from incidents.
- The service did not engage well with staff to plan and manage appropriate services. Staff told us that they were not consulted on issues that affected them and had little input into the improvement of the service to deliver safe care and treatment to patients. Staff told us that they felt that there was a disconnect between the management team and staff.

However:

- Staff told us that everyone worked well together and were supportive of each other. Many of the staff described their work colleagues a “third family”.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

**Please note:** Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website [www.cqc.org.uk](http://www.cqc.org.uk))

**This guidance** (see [goo.gl/Y1dLhz](http://goo.gl/Y1dLhz)) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

| Regulated activity                                                                    | Regulation                                                       |
|---------------------------------------------------------------------------------------|------------------------------------------------------------------|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983 | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment |
| Diagnostic and screening procedures                                                   |                                                                  |
| Maternity and midwifery services                                                      |                                                                  |
| Surgical procedures                                                                   |                                                                  |
| Treatment of disease, disorder or injury                                              |                                                                  |
| Regulated activity                                                                    | Regulation                                                       |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983 | Regulation 17 HSCA (RA) Regulations 2014 Good governance         |
| Diagnostic and screening procedures                                                   |                                                                  |
| Maternity and midwifery services                                                      |                                                                  |
| Surgical procedures                                                                   |                                                                  |
| Treatment of disease, disorder or injury                                              |                                                                  |
| Regulated activity                                                                    | Regulation                                                       |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983 | Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect     |
| Treatment of disease, disorder or injury                                              |                                                                  |
| Regulated activity                                                                    | Regulation                                                       |
| Diagnostic and screening procedures                                                   | Regulation 18 HSCA (RA) Regulations 2014 Staffing                |
| Treatment of disease, disorder or injury                                              |                                                                  |

This section is primarily information for the provider

## Requirement notices

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Nursing care

Treatment of disease, disorder or injury

### Regulation

Regulation 20 HSCA (RA) Regulations 2014 Duty of candour



This section is primarily information for the provider

## Enforcement actions

We took enforcement action because the quality of healthcare required significant improvement.

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

### Regulation

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

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

### Regulated activity

Diagnostic and screening procedures

### Regulation

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

### Regulated activity

Diagnostic and screening procedures

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

# Our inspection team

The inspection was led by Tracey Wickington, Inspection Manager. Fiona Allinson, Head of Hospital Inspection, and an executive reviewer supported our inspection of well-led for the trust overall.

The team included 12 further inspectors, one executive reviewer and 16 specialist advisers.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ.