Norfolk and Norwich University Hospitals NHS Foundation Trust

Inspection report

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Ratings

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

Our findings

Our reports

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

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

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

Overall summary

What we found

Overall trust

Norfolk and Norwich University Hospitals NHS Foundation Trust is a 1,200-bed teaching hospital providing acute care for around 1.1 million people living in Norfolk and Waveney. The trust is one of the largest teaching hospitals in England. It operates from a large purpose-built site on the edge of Norwich and from a smaller satellite at Cromer in North Norfolk. The Norfolk and Norwich Hospital opened in late 2001, having been built under the private finance initiative (PFI). Cromer and District Hospital was rebuilt by the trust in 2012.

The trust offers a range of secondary and tertiary services and has 1,200 acute inpatient beds, 26 critical care beds and 78 maternity beds and employs around 8,011 whole time equivalent staff across the sites. Of these staff 1,165 are medical staff, 2,110 are nurses and 4,736 are classified as other staff (Insight report).

We undertook this unannounced inspection of the following services provided by the trust at the Norfolk and Norwich Hospital:

- Surgery because of concerns about the safety and quality of the service.
- Outpatient Services because of concerns relating to the safety and quality of the service.
- Diagnostic Imaging services because of concerns relating to the safety and quality of the service.

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

Our rating of services stayed the same. We rated them as requires improvement because:

- We rated safe, responsive, and well led as requires improvement. Effective was not rated in all services and caring was not inspected in surgery, diagnostic imaging or outpatient services.
- We rated all 3 of the services we inspected as requires improvement overall. In rating the trust, we considered the ratings of the other services we did not inspect this time.

Our findings

- People could not always access services when they needed it and often waited too long for treatment or had their appointments cancelled. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.
- Services did not always have enough staff to care for patients and keep them safe.
- There was a mixed staff culture at the trust and staff did not always feel supported and valued.

However:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- The services we inspected planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback

Since this inspection in November 2023, the Trust now has a new substantive chief executive officer (CEO). We are assured that the new CEO has a grip on the risks and concerns identified in this report and has already taken steps to drive significant and sustainable improvements in quality and performance.

Outstanding practice

We found the following outstanding practice within Diagnostic Imaging:

- The radiology department had been awarded and maintained the Quality Standards in Imaging (QSI) Award since November 2012. Accreditation is the formal recognition that an imaging services provider has demonstrated that it has the organisational competence to deliver against key performance measures. These measures require the department to achieve high standards of service in relation to patient care and choice, safety, fit-for-purpose facilities, and clinical practices.
- The service had excellent working relationship with the East Anglian Regional Radiation Protection Service (EARRPS), receiving prompt and timely support when required.
- The service had introduced a Quality Assurance (QA) Practitioner, who was the first in the country.
- The service offered same day staging CT scans to all patients who had a probable diagnosis of colorectal cancer identified on the CT virtual colonoscopy (CTC). This greatly improved waiting times, as those patients were referred immediately to the multidisciplinary teams for treatment. British Society of Gastrointestinal and Abdominal Radiology, (BSGAR) standards expect 80% of patients to have same day staging. By implementing this training, the service had gone from 0% compliance to well above the national standard of 80% compliance.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Our findings

Trust wide

- The trust must ensure that staff have received training in treating patients with learning disabilities and autism. (Regulation 18(2)(a))
- The trust must ensure that the systems in place to purchase, renew and replace equipment are responsive, so service delivery is not impacted by equipment failures. (Regulation 15(1)(e))

Core services

Surgery

- The service must ensure that mental health risk assessments are completed for all surgical patients where a mental health need is indicated. (Regulation 12(2)(a))
- The service must ensure World Health Organisation (WHO) surgical safety checklists are completed for all patients. (Regulation 12(2)(b))
- The service must ensure that medicines are stored and recorded in line with policy. (Regulation 12(2)(g))
- The service must ensure that records are updated and stored securely. (Regulation 17(2)(c))

Outpatients

- The service must ensure that all policies and guidelines are up to date and reflect national guidance and recommendations. (Regulation (17)(1))
- The service must have enough staff to care for patients and keep them safe. (Regulation (18)(1))
- The service must keep care records secure. (Regulation (17)(2)(c))
- The service must ensure that they have safe systems for medicines management. (Regulation (17)(2)(f)(g))

Diagnostic Imaging

- The service must ensure that there are processes in place to ensure there are enough suitably qualified and competent staff to make sure that the service can meet targets in respect to waiting times and reporting times. (Regulation 18(1))
- The service must ensure that the systems in place to purchase, renew and replace equipment are responsive, so service delivery is not impacted by equipment failures. (Regulation 15(1)(e))

Action the trust SHOULD take to improve:

Trust wide

- The trust should ensure people can always access care and treatment when they need it and waiting times for treatment are in line with the England average. (Regulation 12)

Core service

Surgery

Our findings

- The service should ensure that staff are aware of where ligature cutters are stored. (Regulation 12)
- The service should ensure that equipment is properly maintained. (Regulation 12)
- The service should ensure medical staff complete mandatory training. (Regulation 18)
- The trust should ensure that their guidance on responding to deteriorating patients is consistently followed (Regulation 12)

Outpatients

- The service should control infection risk well and provide equipment and furniture in line with national standards. (Regulation 12)
- The service should ensure staff feel supported and valued. (18)

Diagnostic Imaging

- The service should ensure that service users are informed of the availability of interpreter services. (Regulation 9)

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.

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

Leadership

Leaders generally had the skills and abilities to run the trust and its services. However, there was not a stable leadership team in place. They were not always visible and approachable in the service for patients and staff. They generally supported staff to develop their skills and take on more senior roles.

Following our previous well led inspection, there had been some significant changes in the executive leadership team and the trust was in a transitional period with some interim roles at executive level. There was an interim chief executive officer (CEO) who had been in post since August 2023 and an interim medical director had been in post since September 2023. The trust Chair was appointed in March 2023, after taking up the interim Chair role in 2022. Other members of the executive team had been in post since 2018 and 2020. At the time of our inspection new leaders were being recruited and inducted into the service.

This meant that whilst leaders had the skills, knowledge and experience required, there was still a significant amount of work to be done to develop a collective leadership team and a unitary board.

The role of the board of directors is to manage the trust's services and develop plans and strategies for the future. The board included 6 executive directors who oversaw the day-to-day running of the trust and 8 part-time non-executive directors (NEDs). The members of the board did not reflect the diversity of the workforce or the communities served (see Culture section for further detail).

Our findings

The NEDs at the trust had complimentary skills, despite this, throughout our interviews with the NEDs and with other executive leaders, we heard the board was not a unitary board and concerns were not always listened to by the executive team. This meant that we could not be assured that the board was clearly sighted on challenges to enable them to identify actions in a timely manner to address them. For example, due to negative feedback and a year-on-year decline or inconsistency in responses, the trust had been placed on enhanced monitoring with the General Medical Council (GMC) through the Regional Post Graduate Dean at NHS England (NHSE). The trust had a series of requirements (must dos) and recommendations (should dos) across the organisation. Our interviews with senior leaders and review of documentation demonstrated that there was not sufficient discussion of the issues at board level and senior leaders were not fully sighted on the significant concern.

Leaders were not always visible in the organisation. We heard mixed responses about the visibility of leadership within the organisation. Leaders told us that they had implemented a new series of board walkarounds whereby a member of the board would visit parts of the trust on a regular basis.

There had been changes in leadership at division level, particularly within the medicine division. The divisional triumvirate leadership teams demonstrated that they were committed to developing their service areas and had employed various mechanisms to empower staff and drive improvements. We saw some evidence of effective working relationships and leadership within the divisional groups, but also saw examples where relationships between teams were ineffective and had resulted in conflict.

As part of our inspection, we undertook checks to determine whether appropriate steps had been taken to complete employment checks for executive staff and reviewed the personnel files of 3 executive and 8 non-executive board members. We found the trust had a process in place to ensure senior leaders were appointed in line with Regulation 5 of the Health and Social Care Act 2014 (Fit and Proper Persons Required - FPPR) and that there was an ongoing review for each person. However, not all members of the board had a current Disclosure and Barring Service (DBS) check. Our review of records and interviews with senior leaders confirmed that the trust did not have a process in place to conduct routine DBS checks for all staff post appointment. Whilst this is not a legal requirement, it is best practice for some assurances that employees are of good character. After our inspection, the trust told us they had developed a proposal to provide for update DBS checking for all staff in the organisation and had updated their FPPR policy in line with recent NHS England guidance.

Vision and Strategy

The trust had a vision for what it wanted to achieve and a strategy to turn it into action.

The trust's vision was to deliver 'the best care for every patient' and this was underpinned by a set of values; People focused, Respect, Integrity, Dedication and Excellence (PRIDE). The trust values were clearly displayed throughout the hospital.

The Trust has five-year strategy, called 'Caring with Pride', which was developed with stakeholders and published in 2022. The new substantive CEO would need some time to review the strategy and objectives and identify any areas they may need to consider to achieve their vision. This could include strengthening the strategy in line with the local plans for the wider health and social care economy.

At the time of our inspection, the trust had been the worst performing trust in the region in a number of key performance areas for the 12 months prior to our inspection. This included ambulance handover times, referral to treatment and cancer treatment waiting times.

Our findings

The interim CEO had identified short-term objectives in line with the trust strategy until the new CEO began employment in February 2024. These objectives were mostly focused on improving patient safety through improving access and increasing patient flow in the emergency department (ED) specifically in relation to ambulance handover and waiting times. These measures were introduced to mitigate risk and improve ambulance handover times, reduce patient waiting times on the back of ambulances outside of the ED and improve access to urgent care for patients in the community waiting for ambulances.

However, these short-term objectives increased the number of patients being boarded in other areas within the service, for example the number of patients waiting in corridors and on wards over and above what ward staff would ordinarily care for. Staff we spoke with told us these new measures had been implemented with limited consultation and that they felt pressured by the wider site teams to take on additional patients when they had made clinical decisions regarding patient safety and care. Staff gave examples of feeding back to the site team regarding patient capacity, only to feel ignored by the site teams, or to have site teams go to the ward to check their clinical decisions. This negatively impacted on the working culture and relationships, with staff feeling undervalued and their clinical decisions not always being respected.

Leaders and staff we spoke with were unaware of how long the short-term objectives would be in place. We asked the senior leadership team and CEO how long the short-term measures would be in place and were told that due to the current demands in the hospital they were unable to give a date for ending the short-term objectives and had no defined plans to move out of escalation.

We received feedback from patient relatives prior to our inspection that the increased patient boarding on wards was impacting on their privacy and dignity. Staff we spoke with also confirmed that this process had impacted on patient dignity and privacy, and that they were constantly balancing this issue with the internal demands to support patient access and flow.

The trust 2022 strategy detailed 5 areas that the trust was committed to developing in order to achieve their vision over the 5-year period. The 5 commitments were:

- Together, we will develop services so that everyone has the best experience of care and treatment **(Our Patients).**
- Together, we will support each other to be the best that we can be, to be valued and proud of our hospital for all. **(Our NNUH Team).**
- Together, we will join up services to improve the health and wellbeing of our diverse communities **(Our Partners).**
- Together, we will provide nationally recognised, clinically led services that are high quality, safe and based on evidence and research **(Our Services).**
- Together, we will use public money to maximum effect **(Our Resources).**

The board had oversight of the trust's strategy and monitored it.

The trust worked collaboratively with stakeholders, other local NHS trusts and the third sector to deliver services to patients.

In addition to the trust wide strategy, the trust had several other strategies that linked together to support the delivery of care. These included the trust's:

Our findings

- Risk management strategy
- People and culture strategy
- Patient engagement and experience strategy
- Digital health strategy
- Quality strategy
- Research strategy
- Dementia strategy
- Mental health strategy
- Cancer strategy
- Medicines optimisation strategy
- Financial Strategy

Culture

Staff were focused on the needs of patients receiving care. The trust did not have effective systems in place to promote equality and diversity in daily work. The trust worked to promote an open culture where patients, their families and staff could raise concerns without fear. However, not all staff felt respected, valued, and supported.

Throughout our core service inspection, we heard that staff did not always feel respected and valued. We heard that empowerment of staff at all levels was a focus for the organisation in terms of culture and moving away from a 'grip and control' culture was key to success.

The Health Education England Quality Framework for post graduate medical and dental education, assesses organisations using a number of data sources, which include the National Education Training Survey (NETS), the General Medical Council (GMC) National Training Survey (NTS) and the NHS Staff Survey, as well as direct feedback from engagement visits with both trainees and trainers/educators. Due to negative feedback and a year-on-year decline or inconsistency in responses, the trust had been placed on enhanced monitoring with the GMC through the Regional Post Graduate Dean at NHS England (NHSE).

Senior leaders were not doing enough to address issues raised by staff feedback. The NHS staff survey results had been static from 2018 to 2023. Generally, the trust has scored lower than the England average in all areas of the NHS People Promises element with significant decline in some areas in the latest 2022 staff survey. We were not assured that the trust was taking effective actions to systematically address concerns raised by staff through the NHS staff surveys and internal mechanisms in a sustainable way. This included measuring improvement when initiatives were implemented. This was reflected in people and culture committee meeting minutes. For example, some of the key issues raised in staff surveys and identified as having a negative impact on culture and staff welfare were staff shortages, managers support and addressing poor behaviours. We were told by staff during the inspection and as part of information submitted following the review, that senior leaders had not addressed poor behaviours that could be described as discriminatory or sexist, which was observed in an interview with inspectors and reflected within the staff survey results.

The Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) reports for the trust demonstrated there was a lack of diversity in senior leadership posts. Within the WRES and WDES reports published in

Our findings

2023 it was reported that there were no black and minority ethic employees with Band 8c and above roles in comparison to 27 white members of staff. There was a total of 14 voting members of the board in 2023, 1 of which was from a black and ethnic minority background. Only 2 board members had disclosed their disability status, and the remaining 13 members were unknown.

The 2023 WRES data showed that 35.6% of black and minority ethnic staff experienced bullying, harassment, or abuse from other staff. In addition, the NHS survey along with the WDES showed that 32% of staff living with a disability had experienced bullying from other staff compared with 22% of staff who did not have a disability. Similarly, 34.5% of staff who identified as LGBT+ experienced bullying and harassment at work from other staff at work, compared to 23.6% of staff who identified as being heterosexual.

The trust had an action plan to tackle the WRES results, this was developed in 2022 and was to run until 2025. The action plan had outcomes and a date for completion, however, the action plan did not have a named accountable person attached to ensure accountability for the outcome.

Senior leaders we spoke with recognised there were some changes that needed to be made in relation to the culture of the organisation. They recognised that data emerging from recent reports had reinforced the poorer experiences of people from a Black, Asian, and Minority Ethnic (BAME) background. This was shown in the staff survey results and the WRES report had made it clearer that the day-to-day experiences of BAME employees was not as positive as it should be. In response to this, the trust had launched an NHSEI East of England anti-racism strategy and a union anti-Racism charter. The NHSEI East of England strategy aimed to tackle racism and improve the experiences of staff by defining what it meant to be an anti-racism organisation. It was not clear how this strategy would support the trust to understand their unique issues and how it linked to the trust own diversity and inclusion strategy which had recently been developed. We were told that diversity and inclusion was not effectively discussed at board level and our review of documentation confirmed this.

Senior leaders acknowledged that there was work to do to improve the culture of the organisation at all levels. The trust had a 5-year People and Culture strategy focused on the 7 NHS People Promises. The trust had recently developed a 'diversity, inclusion and belonging strategy' as part of the people and culture strategy. This was launched in October 2023, just before our inspection. The trust's diversity and inclusion vision was to create a hospital for all people, where everyone feels a sense of belonging. One of the most recent actions taken (October 2023) was the establishing of a short-term cultural change board with diverse membership. The purpose of this board was to have oversight of the cultural change programme and establish foundations of defined behaviours for staff at all levels including senior leaders. There had been other initiatives introduced such as 'license to lead' leadership programmes and plans to implement electronic staff rostering and other processes to address work-related challenges raised by staff. Our interviews with senior leaders and review of documentation demonstrated there was not yet a clear process to ensure that any actions taken were measured and monitored to establish whether they were effective. Senior leaders recognised that, the staff survey and workforce data reflecting the lived experience of staff, demonstrated they had more to do before they could say the workplace was inclusive.

The Equality Delivery System (EDS) is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010. The EDS was developed by the NHS, for the NHS, taking inspiration from existing work and good practice. EDS 2022 is a generic system designed for both NHS commissioners and NHS providers. The trust used the Equality Delivery System (EDS) as a tool to help them deliver against their statutory requirements in relation to staff and patients. The trust published its EDS 2022 report in April 2023.

Our findings

The trust had developed a trust wide action plan in order to learn from where they were showing best practice and where there was a need for improvement.

The trust took part in the NHS England NExT Director Scheme. This was a development programme created and designed to help find and support the next generation of talented people from groups who were currently under-represented on the trust's NHS board into non-executive roles.

The trust had undertaken some work to strengthen the Freedom to Speak Up Guardian (FTSUG) function and capacity, which had been well received by staff. The trust employed a lead FTSUG and had an established network of trained Guardians and Champions to support staff who wished to speak up about concerns or issues. Staff told us they could raise concerns with their managers but could also raise concerns with the FTSUG if necessary.

The Freedom to Speak Up service provided quarterly reports to the People and Culture Committee. Reports were also provided to the hospital management board. The lead FTSUG presented a report at the September 2023 Board Meeting which identified the most common speak up theme concerned staff relationships.

People who received care at the trust and their relatives and carers could raise concerns and complaints to the trust through the patient advisory liaison service (PALS), friends and family tests and patient feedback surveys. Our review of documentation provided by the trust demonstrated there were processes in place to ensure duty of candour was undertaken when required. Complaints were generally managed in line with trust policy and there was evidence of learning from complaints.

The trust continually monitored Duty of Candour and generally met the trust target of 95% with a mean compliance rate of 97%.

Governance

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

The trust had effective structures, systems, and processes in place to support the delivery of its strategy. Ward to board assurance was provided from divisions through the trust's board assurance committees. These included the Norfolk and Waveney committees in common, quality and safety committee, people and culture committee, audit committee, nominations and remunerations committee, finance, investments and performance committee and major projects assurance committee. These committee meetings were chaired by non-executive directors. This enabled them to obtain direct assurance from service leads and deliver this to the board.

The trust governance framework including committee and performance reports meant the board could receive timely data as required.

The trust had introduced annual governance statements for each division. This was a positive step in strengthening accountability at divisional level.

The trust also had a council of governors who had been elected by members of the public and staff. The governors' role was to hold the non-executives to account for the performance of the board of directors and to represent the interests of the members and the public.

Our findings

The Integrated Care System (ICS) within which the trust provides services was recognised as one of the most challenged in England. The trust had as one of its strategic objectives "Together we will use public money to maximum effect." The trust told us that it had a financial strategy which reduces its underlying financial deficit from £114m to circa £14m over 5 years from 2019/20. In July 2022, and repeated in September 2023, the service completed an assessment of its use of resources, drawing on a wide range of productivity and effectiveness benchmarks; and implemented a tactical action plan to evidence its improved use of resources. The trust's self-assessment demonstrated that its use of resources required improvement.

The terms of the trust's PFI contract meant that close liaison was required between the trust and its contracted facilities management providers. The Chief Finance Officer described how he had strengthened governance and performance management arrangements with a specific PFI liaison committee that supported the trust / PFI contract interface, reporting to the Board through the Finance, Investments and Performance Committee. The trust told us that it had a detailed PFI management policy in place and in 2024 it would continue to plan actively with PFI partners for the managed handover and return of the PFI estate at the end of the contract period.

External auditors had given an unqualified opinion on the 2022-23 accounts, including the value for money opinion covering arrangements for securing value for money; governance and financial sustainability. The trust's internal audit provider had given the trust assurance that the operation of its internal controls was adequate.

Management of risk, issues, and performance

Leaders and teams did not always use systems to manage performance effectively. They mostly identified and escalated relevant risks and issues. They did not always identify actions to reduce their impact. They had plans to cope with unexpected events.

In the 12 months prior to our inspection, we saw that the performance at the trust had been below the national average in a number of key performance areas related to quality care. This included metrics related to cancer waiting times where the trust was performing poorly nationally and regionally. For example, at the time of our inspection the trust was highlighted as one of the 15 most challenged organisations nationally for cancer recovery. In October 2023 the trust was the second worst performing trust in the country for patients waiting 62 days for their first treatment after a cancer diagnosis. From November 2022 to October 2023, ambulance handover delays ranged from 35-57% of handovers taking more than 60 minutes compared to the regional average of 9-18%. Senior leaders told us this had a significant impact as ambulances were less able to respond to 999 calls in the wider community and patients waiting on ambulances had poor experiences.

Access and flow through the hospital was a long-standing risk due to delays for ambulance offloads, delays in the emergency department and delays in discharging patients from the ward areas. The trust had been challenged with identifying actions to improve performance in this area for the 12 months prior to our inspection.

At the time of our inspection, the interim CEO had implemented short-term strategic objectives focused on the patient's journey and safety in terms of ambulance handover delays, referral to treatment times and elective recovery. A significant number of actions had been taken to reduce ambulance handover delays to minimise patient safety risks in the community when ambulances were unable to respond. This had seen positive results over the previous few weeks; however, we were concerned that some of the actions such as 'boarding' would become normalised, especially as winter could potentially bring more challenge and we had identified that the short-term objectives were impacting on staff and patient culture. Following our inspection, the trust provided us with information that outlined actions to be taken to recover from this position by the end of December 2023.

Our findings

The board was responsible for ensuring the trust had appropriate processes for risk identification and risk management. The trust had arrangements for identifying, recording, and managing risks and staff had access to their risk register either at a team or division level and could escalate concerns as needed.

The corporate risk register fed into the trust's board assurance framework (BAF). Corporate and principal risks to strategic commitments were also recorded on the BAF. The BAF set out the strategic commitments, identified threats to achievement of each strategic objective and set out the controls required and assurances available for their operation. At the time of our inspection, the BAF had last been reviewed by the audit committee in June 2023 and reported to the board of directors in July 2023.

The trust risk registers clearly defined actions required to address and/or mitigate the risk as well as arrangements for review and appropriate oversight as well as a named risk owner. All leaders we spoke with were able to identify the top risks that were being managed through the corporate risk register.

The trust had an agreed process for the escalation of risk. Each directorate had a risk lead that worked with the teams to assess and score risk. Any risks scored between 8 and 12 were managed at divisional level and those with a risk score 15 and above were reviewed and agreed by the risk oversight committee and the hospital management board. If a risk was agreed to be 15 or more, it was entered onto the corporate risk register and shared with the appropriate board committees who were responsible for assuring the board that the risk was being managed.

The trust had responded to the 2017 NHS National Quality Board guidance on Learning from Deaths and the 2016 CQC report 'Learning, candour and accountability' and had published a learning from deaths policy. The trust had established a learning from death committee to oversee mortality outcomes and the effectiveness of the mortality review at trust wide level. This was chaired by the associate medical director for Quality and Safety.

The trust had also introduced a mortality surveillance group. This group had been established as a sub-group of the trust's learning from deaths committee. The purpose of the mortality surveillance group was to ensure oversight of the trust's benchmarked mortality rates and associated investigations and ensure that learning from these investigations translated into improvements in clinical pathways. This group was also chaired by the associate medical director for quality and safety.

Information Management

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

At the time of our inspection, the trust records were a combination of paper and electronic. The trust had an ambition to become a digitally advanced hospital and an outline business case for an electronic patient record system had been approved by NHS England with a plan to implement in 2025.

The trust had launched a new digital platform to make it easier for patients to request outpatient follow up appointments. The aim of the patient initiated follow up appointments was to free up clinicians to enable them to concentrate more on new appointments, diagnostics and procedures for patients who were most in need.

Our findings

The services had clear performance measures which were reported and monitored in various forums. There were effective arrangements to ensure the information was used to monitor, manage, and report on quality and performance and that this was accurate, valid, reliable, timely and relevant.

The trust had effective arrangements in place to ensure data and notifications were submitted to external bodies as required.

Arrangements were in place (including appropriate internal and external validation) to ensure the availability, integrity, and confidentiality of identifiable data, records, and data management systems in line with data security standards.

Engagement

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

The trust was part of the Norfolk and Waveney Integrated Care System (ICS)

The trust had a patient engagement and experience strategy, which set out an ambition that the patient voice stands shoulder to shoulder with that of clinicians and other staff across the organisation and across Norfolk and Waveney. The strategy supported the trust's 5-year corporate strategy and its quality and safety improvement strategy.

The trust had an activity plan for engaging with patients and kept a record of all engagement events that took place between 2022 up to the date of our inspection. Engagement and listening events had taken place with several stakeholder groups including but not exclusive to patients, young carers, carers, Gypsy, Roma and travelling communities, Healthwatch, those who were neurodiverse, new mums, pregnant people, those with a hearing impairment and those who were living with a disability.

The trust also had a patient panel who reported into the patient engagement and experience group (PEEG) who shared updates with the quality and safety committee, the management board and ultimately the trust board. Each member of the patient panel had lived experiences, professional knowledge and came from diverse backgrounds.

The trust had a 5-year people and culture strategy which supported the caring with pride strategy and supported the delivery of the trust's people promise. The People Promise delivery plan was agreed followed extensive engagement across the organisation, including staff networks and trade unions, and the staff survey outcomes were used to inform potential actions.

The trust participated in an annual staff survey and the response rate for 2022 was 51%. This was a slight improvement from 49% in the 2021 staff survey.

The trust had a staff council. The purpose of the staff council was to provide a forum enabling staff to engage and directly input into staff survey actions and priorities, and the longer-term actions required to deliver the people and culture strategy. Meetings took place on a monthly basis. The trust told us, in addition to the newly established staff council, they also had:

- Well established Partnership Working with the Joint Staff Consultative Committee, including representation of all recognised unions and the BMA, which meets monthly.

Our findings

- Number of staff Networks, including NNUH Together (BME), Women's Network, LGBT+ and Diverse Ability Group (Disability), which also meet monthly.

There were several areas where leaders at all levels were working with external partners in care to improve the delivery of care in areas such as the community and mental health. The trust also worked in partnership with the other acute NHS trusts in the region.

Learning Continuous Improvement and Innovation

All staff were committed to continually learning and improving services. They were developing a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The trust had several evidence groups that worked collaboratively across the trust to provide assurance and develop ways of working across specific areas of care.

Key to tables

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

Month Year = Date last rating published

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement →← Aug 2024	Good →← Aug 2024	Good →← Aug 2024	Requires Improvement →← Aug 2024	Requires Improvement →← Aug 2024	Requires Improvement →← Aug 2024

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
Norfolk and Norwich University Hospital	Requires Improvement → ← Aug 2024	Good → ← Aug 2024	Good → ← Aug 2024	Requires Improvement → ← Aug 2024	Requires Improvement → ← Aug 2024	Requires Improvement → ← Aug 2024
Overall trust	Requires Improvement → ← Aug 2024	Good → ← Aug 2024	Good → ← Aug 2024	Requires Improvement → ← Aug 2024	Requires Improvement → ← Aug 2024	Requires Improvement → ← Aug 2024

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

Rating for Norfolk and Norwich University Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires improvement Feb 2023	Requires improvement Feb 2023	Good Feb 2023	Good May 2019	Requires improvement May 2019	Requires improvement Feb 2023
Surgery	Requires Improvement → ← Aug 2024	Not rated	Good Apr 2020	Requires Improvement → ← Aug 2024	Requires Improvement → ← Aug 2024	Requires Improvement → ← Aug 2024
Services for children & young people	Requires improvement May 2019	Good May 2019	Good May 2019	Requires improvement May 2019	Requires improvement May 2019	Requires improvement May 2019
Critical care	Requires improvement May 2019	Good May 2019	Good May 2019	Good May 2019	Requires improvement May 2019	Requires improvement May 2019
End of life care	Good Apr 2020	Good Apr 2020	Outstanding Apr 2020	Good Apr 2020	Outstanding Apr 2020	Outstanding Apr 2020
Urgent and emergency services	Good Jul 2021	Good Apr 2020	Good Apr 2020	Requires improvement Jul 2021	Good Jul 2021	Good Jul 2021
Diagnostic imaging	Good ↑ Aug 2024	Not rated	Good Jun 2018	Requires Improvement → ← Aug 2024	Requires Improvement → ← Aug 2024	Requires Improvement → ← Aug 2024
Outpatients	Requires Improvement → ← Aug 2024	Not rated	Good → ← Aug 2024	Requires Improvement ↓ Aug 2024	Requires Improvement ↓ Aug 2024	Requires Improvement ↓ Aug 2024
Maternity	Good Feb 2024	Good May 2019	Good May 2019	Good May 2019	Good Feb 2024	Good Feb 2024
Overall	Requires Improvement → ← Aug 2024	Good → ← Aug 2024	Good → ← Aug 2024	Requires Improvement → ← Aug 2024	Requires Improvement → ← Aug 2024	Requires Improvement → ← Aug 2024

Norfolk and Norwich University Hospital

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Outpatients

Requires Improvement ↓

Is the service safe?

Requires Improvement →←

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

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training. The service set compliance targets throughout the year. For example, we reviewed training compliance across services, staff compliance was above 90% across the ward areas we visited. Staff within the outpatient's oncology department achieved 91% compliance, ear nose and throat department were 94% compliant, and medical outpatients were 94% compliant with mandatory training.

The mandatory training met the needs of patients and staff. Mandatory training courses included health and safety, infection prevention and control, equality and diversity and information governance as well as other key topics.

Managers had access to all training records for staff and would remind them to complete mandatory and additional training. Staff told us they were given protected time to complete their training.

We asked for compliance figures for mandatory training specific to outpatient staff working with autism and learning disabilities, however they did not provide us with the data.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. All staff were required to complete combined levels 1 and 2 safeguarding training for adults and children annually. Staff with a clinical registration were required to complete level 3 safeguarding adults and children training.

Outpatient nursing staff compliance with safeguarding adults and children training was above 90%.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had a safeguarding lead for adults and children and a named nurse. The safeguarding leads were appropriately trained to level 4 safeguarding for adults and children.

Staff knew how to identify adults and children at risk of or suffering significant harm and worked with other agencies to protect them. Staff gave us examples of when they had escalated concerns to safeguarding agencies and worked together to keep people safe. The service had safeguarding policies available to support staff and these could be accessed on the services intranet. Staff we spoke with knew who the safeguarding leads were and told us how they accessed safeguarding policies. Safeguarding information, contacts, and a visual flow chart that outlined the safeguarding referral processes to follow were displayed in staff areas for ease of reference.

Outpatients

Chaperones were offered to patients for any procedure. However, it was not always clear to people using the service that they could ask for a chaperone. For example, we did not see signs for a chaperone in every area.

Staff followed safe procedures for children visiting the service and during our inspection children attended some of the outpatient departments, for example, in the ear, nose and throat and eye clinics. Each department had a child appropriate area and appropriate children's activities.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. However, not all equipment was visibly clean and some equipment did not meet infection prevention control compliance standards.

Staff received mandatory training in infection prevention and control (IPC) and there were infection prevention and control policies and procedures in place, which provided further guidance for staff.

The service had an IPC lead who oversaw infection control processes and provided support for staff. The lead shared infection incidents and managed IPC audits, IPC training and updates in relation to policies and national guidance.

Most clinical areas clean and well maintained. However, in one eye clinic, the furnishings did not meet regulations and standards. For example, in the eye clinic reception area, chairs were not wipeable, and some chairs were damaged.

Staff completed daily clinical cleaning schedules. Cleaning records were mostly completed to demonstrate all areas were cleaned. However, in an oncology area three oxygen cylinders we looked at were visibly dusty and dirty and had not been cleaned as was indicated on the cleaning schedule.

Hand hygiene and cleaning audits were carried out and staff compliance was displayed in public areas. Staff followed IPC protocols including the use of personal protective equipment. We reviewed IPC audits from July to September 2023, and found the areas we visited were 100% compliant.

Staff followed hand hygiene and 'bare below the elbow' guidance appropriately. Toilets had signs to remind patients and staff to wash their hands and displayed guidance on how to wash hands effectively. The service had a hand sanitising stations at all entrances and throughout patient waiting areas. Staff carried out hand hygiene audits. We looked at data from June 2023 to September 2023 which demonstrated variable rates of compliance. For example, the oncology outpatient department we visited were 93% compliant in September and ear, nose and throat were 100% compliant in September 2023.

Disposable curtains in clinical rooms were regularly replaced and renewal dates were clearly recorded on the curtains.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment generally kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The service did not always have suitable facilities to meet the needs of patients' families. The design of the location meant outpatient departments were placed across the hospital. Each area was different. Some areas were less favourable than others, for example, staff in oral health told us there could be more space to provide necessary privacy to share bad news.

Outpatients

The service did not always have enough suitable equipment and resources to help them to safely care for patients. Staff within the oral health outpatient area told us they had new dental chairs on order to replace the older style chairs they had and we noted that the chairs were on order and on the risk register.

Staff disposed of clinical waste safely. Clinical areas had foot operated clinical waste bins. Staff had access to sharps bins which were clean, not over filled, dated, signed and secure.

Staff mostly carried out daily safety checks of specialist equipment. We looked at equipment in all areas we visited and resuscitation trolleys were correctly stocked; oxygen cylinders were full and defibrillators were in working order. All emergency equipment was secured with a seal tag. Staff carried out daily safety checks daily of emergency resuscitation equipment. However, on the oncology day unit although checklists had been signed daily, the checks had not been completed. For example, staff did not check that suction machines were connected.

There were fire extinguishers throughout the premises, and these had been tested appropriately. Fire safety training was also included as part of mandatory training and staff had completed this.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff knew how to respond to sudden deterioration in a patient's health. Staff could access a deteriorating patient and severe patient injury flowchart to establish when a patient needed an emergency transfer to another department within the service , for example to urgent and emergency care.

Staff used a patient transfer checklist that included tasks such as documenting the reason for transfer and that allergies, medication and medical history were recorded in the patient notes. Nursing staff also use situation, background, assessment, recommendation (SBAR), a nationally recognised communication tool, to handover care between clinical staff.

Patients were risk assessed at their appointment booking stage, on admission and prior to discharge. Staff understood that patient risks changed and reviewed patient risks regularly. Staff risk assessed patients for allergies, medical history, and medication.

Staff used and described tailored Local Safety Standards for Invasive Procedures (LocSSIPs) to help reduce risks and ensure safety. The service had range of customised LocSSIPs to help maintain safety standards across services.

Staff documented alerts to indicate if patients had allergies, adverse drug reactions or were diabetic. Staff also indicated dementia and learning disabilities as alerts to help understand a patient's potential risks in advance of their appointments. Staff knew about and dealt with any specific risk issues. Staff used risk assessments for venous thromboembolism to help reduce the risk of blood clots, risk of falls and infection control risks.

Mental health staff were available to support patients with mental health conditions. Nursing staff told us they could access mental health support in working with patients with mental health needs.

Staff shared key patient information when handing over their care to others during the morning staff huddles, shift changes, and multidisciplinary team meetings. Staff met face-to-face and used technology to allow people from across services to come together to share information.

Staff had access to first aid kits and emergency anaphylaxis kits for both adults and children.

Staffing

The service did not always have 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. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency, and locum staff a full induction.

The service did not always have enough nursing and support staff to keep patients safe. Staffing was raised as a concern across departments. For example, cardiology outpatients from March 2023 to August 2023 had an increase in nursing vacancies with 4 whole time equivalent (WTE) vacancies in March 2023 increasing to 5 WTE vacancies in August 2023. The outpatient staff turnover was high, for example ophthalmology staff leavers were at 11% in the year up to August 2023.

Leaders had oversight of the departmental vacancies. Staffing was flagged at a variety of monthly team, divisional and governance meetings and reported on quality boards. Leaders worked together to plan ahead and roll out recruitment campaigns.

Some staff groups were on the risk register which was updated when new risks emerged. For example, orthodontics staffing was entered as a new risk on the divisional risk register in August 2023.

All bank staff were current employees which meant they had already had a full induction and understood the service. Leaders and staff told us the outpatient department used a high number of bank staff across all areas. We asked for data and were unable to determine specific numbers based on the information received.

The service did not have enough medical staff in some departments to keep patients safe. Orthodontics medical staffing vacancies were at 52%. There had been some improvement in medical staffing in the ophthalmology day unit. Medical staffing vacancies in March 2023 were at 16% and in August 2023 the number of vacancies decreased to 2%.

Managers used a safer staffing tool to determine the number and skill mix of staff required each day depending on the types of appointments and procedures taking place. Staff attended weekly planning meetings to identify any shortfalls in staffing and used a red flag system to escalate unsafe staffing levels. Red flags included insufficient skilled staff to cover booked procedures or safe staffing levels not meeting minimum requirements.

Records

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

The outpatient department used a combination of electronic and paper systems for patient records. The service was in the process of migrating to a new electronic record system which had not been fully implemented at the time of our inspection. Staff told us the roll out of the new system was a longer-term project with a deadline for completion in 2026/27. Staff reported some concerns in relation to the new electronic record system, however they appreciated that the roll out of the system was incomplete and not yet embedded.

Not all patient records had been migrated on to the service's new online system. In these instances, paper records were used to determine patient historical data and update information. We reviewed 10 outpatient records. The patient records we looked at clearly recorded information which included referral records, consent forms, consultation summaries and discharge letters.

Outpatients

Medical records were not always securely stored. Staff left patient records unattended in corridor areas in oral health and in unattended rooms in the eye clinic department. Staff removed the unattended trolleys as soon as we alerted them to it.

Staff discussed records security at the outpatients staff forum. Staff shared their discussions with the Health Records Security subgroup. As a result, new notes trolleys were designed to improve the management of patient notes. Records trolleys were either on order or received and in use.

There was a medical records team who prepared patient records in advance of patients' appointments.

Medicines

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

Staff had an up-to-date medicines policy and procedure which had been regularly revised. The most recent policy was dated June 2023. The policy had been authorised and signed off by the Pharmacy and Drugs, Therapeutics and Medicines Management Committee. The policy and procedures were comprehensive and accessible electronically to all staff.

The service had an onsite pharmacy department and all medicines were procured for audit purposes through the onsite pharmacy.

Staff did not store and manage medicines in line with policy. For example, in the outpatient oncology department staff left medicine cupboards unlocked, with controlled drugs which was not in line with the services medicines policy.

Medicines were not always stored safely. Staff in the outpatient oncology service left medicines cupboards unlocked for ease of access and this was not always in line with the service' medicines policy and procedure for safe medicines storage. A pharmacy team based at the service were responsible for completing stock checks and medicines management audits.

Medicines that required storage at temperatures between 2ºC and 8ºC were appropriately stored in medicine fridges. There was a system in place that alerted staff when the fridge temperature exceeded the maximum temperature range. Staff completed medicines records accurately and kept them up to date. Each patient had a medication form that documented allergies, what medicines had been administered and what medicines were given on discharge.

Staff told us they had concerns relating to sufficient supplies of chemotherapy for patients using the outpatient oncology services. This was on the service's risk register.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff reported incidents using an electronic incident reporting system. The system sent notifications to senior staff to review and follow up incidents where appropriate. The system also allowed reports to be run and data to be audited.

Outpatients

Staff we spoke with understood the duty of candour process and were able to give examples of when this had been followed. The duty of candour is a regulatory duty that relates to openness and transparency with patients if their treatment causes or has the potential to cause harm or distress.

Staff received feedback from investigation of incidents, both internal and external to the service. The service was an adopter of the Patient Safety Incident Response Framework (PSIRF) which was in line with the 2019 NHS Patient Safety strategy. This way of managing incidents was introduced in September 2023.

Staff shared learning from incidents in a 'Learning Zone'. The initiative provided staff with the opportunity to learn and improve. Staff used themes identified in recorded incidents to conduct thematic reviews. One thematic reviewed we looked at related themes of delays as a result of staffing, capacity and demand issues in outpatients in ophthalmology.

There had been no never events reported by the outpatient department in the 12 months prior to our inspection. A never events are serious incidents that are entirely preventable.

Staff met to discuss the feedback and look at improvements to patient care. The service held safety huddles every morning with managers and staff from outpatients and other departments. They shared incidents at the safety huddles and also with other local services for learning and improvements.

Is the service effective?

Inspected but not rated

Evidence-based care and treatment

The service did not always provide care and treatment based on the most up to date national guidance and evidence-based practice.

Staff did not always have access to up to date policies to plan and deliver high quality care according to best practice and national guidance. For example, staff in oral health and one of the eye clinics were using out of date guidance documents.

Departmental processes reflected national guidance such as National Institute for Health and Care Excellence (NICE) guidelines and World Health Organisation (WHO). Changes to clinical practice and policies were discussed at routine meetings.

Outpatients staff used local safety standards for invasive procedures (LocSSIPS) based on the World Health Organisation (WHO) safety checklist to help improve patient safety.

Staff provided flexible and adapted support to patients with additional needs, such as learning disabilities and mental health conditions.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs. The service made adjustments for patients' religious, cultural and other needs.

Outpatients

Staff provided patients with food to eat and drink where appropriate. Including those with specialist nutrition and hydration needs. Patients and their families gave us feedback about the volunteers employed by the service to support people for example while having chemotherapy. The volunteers provided a regular flow of food and drink to people who wanted it and where it was safe to give.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. For example, a speech and language therapist supported patients in oral health and ear, nose and throat outpatient departments.

Pain relief

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

Patients were assessed for pain symptoms during outpatient appointments using a recognised pain scale. Patients that underwent certain treatments (such as injections) were assessed and monitored by staff as part of their routine observations to identify and manage pain symptoms.

Patients were supported in managing pain through prescriptions with the appropriate pain-relief medicines. Patients were prescribed pain relief medicines to take home and given advice on how to manage pain symptoms following discharge after certain procedures.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service monitored patient outcomes and data showed positive results. For example, in July 2023, the friends and family feedback was 100% positive with 31 compliments. The Friends and Family tool provided patients with the option to review the service. Patients also left feedback on improvements, for example, we saw that patients valued virtual appointments, however they would prefer more choice. As a result, the service reported that they offered flexibility and choice.

The service participated in relevant national clinical audits. Staff used an electronic audit system as a platform to collect and analyse data. Staff used the data to make improvements across the service and for patients and staff. Divisional Nurse Directors reviewed and discussed the data as part of a monthly review.

Managers and staff carried out a programme of repeated audits to monitor effectiveness of care and used the results to improve patient outcomes. An additional dashboard provided staff a quick glance at how many audits had been completed and provided a breakdown of the top 5 poorest scoring to help plan for improvements.

Patient outcomes were a standard agenda item in clinical governance meetings. We looked at minutes where patient outcomes items included national and local audit reporting. There was benchmarking, actions, and compliance. Staff discussed data and themes in relation to late running clinic audit data from January to June 2023 outlining issues and consequences.

Outpatients

Managers used information from the audits to improve care and treatment. Staff completed audits once a week with a focus on various aspects of care within the clinical environment. Daily safety was a key domain, as was compliance with mandatory training.

Managers and staff used the results to improve patients' outcomes. Care assurance audits involved senior staff and peer review process, to learn from each other. Staff involved in audits collaborated and shared outcomes and ideas. This encouraged peer learning for all, including the audit team and became an extension of the outpatient staff forum.

Senior staff completed an outpatient care assurance unannounced inspection. These internal inspections were supported by the service's Integrated Care Board, colleagues, patient panel members, estates and facilities colleagues and governors. Care Assurance permitted staff to review cleaning, general environment, patient experience, and medication management.

Matron quality assurance audits were conducted. Matron led audits helped prepare staff for external audits and reviewed compliance of the quality auditing within the outpatient departments.

Staff provided feedback following internal audits and followed up with a formal report with actions. Where appropriate and if required, the clinical quality improvement team arranged a further unannounced inspection within 2-4 weeks for those areas under 69% to encourage improvements.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff were supported in their competence by a clinical education team which included practice development and education staff. Competency and educational support was offered to student nurses, supervised practice nurses, return to practice nurses, overseas supervised practice nurses, new nursing assistants and clinical mentors.

Staff completed core and clinical competency training during induction and optional training which was relevant to their role. Core competencies included dementia training, anaphylaxis reactions and incident reporting. Clinical competencies included wound care, administration of oxygen and cannulation. Outpatients staff had also completed optional training in other areas such as administering controlled drugs.

Managers gave all new staff a full induction tailored to their role before they started work.

Managers supported staff to develop through yearly, constructive appraisals of their work. We reviewed appraisal compliance data across departments and found the oncology outpatients department staff were 97% compliant, ear nose and throat were 93% compliant and medical outpatients department staff were 95% compliant with their appraisals.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. The service employed clinical educators to provide regular training and supervision to support competencies, learning and development.

Professional nurse advocates supported nursing staff. For example, if they had experienced a challenging situation or incident. In addition, they offered professional revalidation support. Staff told us they were a valuable resource. Manager told us and we saw documented the role that the professional nurse advocates played in supporting staff mental health and wellbeing.

Managers identified any training needs for their staff team and gave them the time and opportunity to develop their skills and knowledge. Staff we spoke with gave examples of their continual professional development. For example, nurses in ear, nose and throat service told us they attended paediatric study days to keep their skills updated for working with children.

Managers identified poor staff performance promptly and held performance improvement meetings to support staff if required. The service had a policy for managing poor performance which set out a clear process that was focused on fairness, confidentiality, and integrity.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff could access team meetings minutes electronically. Staff shared information about team meetings in local team huddles, on the intranet and in newsletters.

Managers recruited, trained and supported volunteers to support patients in the service. The hospital had 450 volunteers as of September 2023. The service recognised the contribution made by volunteers in their monthly newsletter which was freely available at the services entrances.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. This included morning safety huddle meetings for staff to discuss staffing, patients, and procedures for that day.

Consultants from various specialities shared their knowledge and expertise and discussed patients at multidisciplinary meetings. The multidisciplinary meetings also reduced the financial and time cost of multiple appointments for patients. The service also had representation at the partnering services sites at daily safety huddle to share planned activity and discuss any current risks.

Consultants worked closely with clinical and administration staff to share patient information with general practitioner (GP's) and other relevant professionals.

Seven-day services

The outpatient department was available five days a week.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests. Staff could use on site diagnostic services and local mental health services and leads.

The outpatient department was open 5 days a week, Monday to Friday from 8am until 8pm.

Managers were available on call out of hours for any urgent enquiries.

Outpatients

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on display in patient areas. Staff we spoke with explained this could be provided in other formats to support patients whose first language was not English.

There were health promotion noticeboards containing information about smoking and alcohol cessation, cancer care, falls, weight management and caring for dementia. Patients could request copies of the information leaflets at the reception desk.

Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff could describe the principles of capacity. For example, staff told us they would assume a person had capacity and they would support patients to make their own decisions even if those decisions appeared unwise.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. Staff we spoke with said if they had concerns regarding a patient's capacity, they would seek support from their senior members of staff or the safeguarding leads. Staff made sure patients consented to treatment based on all the information available.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We saw signed patient consent within patient records. We reviewed 10 sets of patient notes and saw that these all had consent forms that had been signed by the patient. Staff gained consent from patients for their care and treatment in line with legislation and guidance.

Staff made sure patients consented to treatment based on all the information available. Staff spoke with patients and their families about the treatment they were consenting to in order to ensure they understood and had fully consented.

Patients whose first language was not English could access an interpreting service available to help with the consent process.

Is the service caring?

Good 

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

Outpatients

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. One patient told us that although they had a long wait, staff communicated regularly with them to keep them updated.

Patients said nursing staff treated them well and with kindness. We spoke with one patient who told us staff made them feel welcomed and at ease. One patient and a family member told us the care they received was first class and that staff were kind and welcoming. They shared their admiration for how hard staff worked to care for them and gave special consideration to the volunteers. However, two patients from different departments reporting feeling dismissed by doctors and lack of compassion.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff asked patients if they wanted help making a drink and took time to talk with them in the waiting room.

Information on privacy and dignity was displayed on the display screen in the waiting area. It informed patients that they could speak to staff privately and outlined ways that staff would respect their dignity. One patient and their partner told us they observed staff care for people in a dignified way, for example pulling curtains to maintain privacy.

Staff shared examples of when they had altered their working patterns to accommodate urgent assessments.

Patients said staff treated them well and with kindness. One patient, who attended many times a week for their treatment told us “You couldn’t beat the care received”.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. The service had a chaplaincy service. Staff gave us examples of when they had provided emotional support. A patient told us they had received emotional support. There was a helpline number they could call to speak directly with staff if they were distressed.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Medical outpatients had an allocated confidential space for the purpose of delivery of important or bad news for patients.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. One patient shared their gratitude in relation to a nurse who noticed their distress outside of the department. The nurse checked in with the patient again at their next appointment. Staff checked regularly with patients in the oncology outpatient department to assess their wellbeing and those close to them. Staff had the option to direct people to the chaplain for additional emotional support. There was a chaplaincy team for confidential support to people of all faiths and beliefs. A head of spiritual care carried out walks around the departments to offer a visual presence and offer emotional support.

Outpatients

There were cancer support and wellbeing sessions. This included information and a range of initiatives for people recently diagnosed with cancer. There were Macmillan mobile information boards around the hospital and leaflets with event timetables that people could attend. There were a wide range of health and wellbeing events. For example, hand massage, dietary information, local mental health services for therapeutic input and yoga.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. We observed an interaction between a nurse and a patient. The nurse clearly communicated options and advice in relation to mobilisation. We observed an interaction between a dentist and their patient clearly communicating in advance what to expect during their treatment.

Staff supported patients to make informed decisions about their care. We attended clinics and observed staff and patients and in some cases their carers discuss care, treatment options and decide on what would work best for them. For example, a nurse and doctor provided a patient and their carer with information and gave them time to consider the options discussed before deciding their treatment choices.

Patients gave positive feedback about the service. One patient and their partner shared that their "consultant was fabulous". A free service newsletter was made available at the entrances to the different departments at the service. People shared positive stories about their visit in the service newsletter. Friends and family feedback was on display in patient areas which demonstrated overwhelmingly positive feedback from people using the services.

We observed a patient attend with their carer. We spent some time observing them in their consultation. We saw kind and engaging communication between all parties, which was adapted to help the patient feel part of their patient journey and comfortable throughout.

Is the service responsive?

Requires Improvement ↓

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

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the changing needs of the local population. Leaders were involved in a wider transformation programme to help staff work smarter. The programme considered local demographics, technological advances and working collaboratively with the local health economy. The transformation programme considered the economic status of the local population and the considerable impact of the cost of living on the community.

Outpatients

The service minimised the number of times patients needed to attend appointments using the option of virtual technology. Staff used digital and virtual technology to help patients avoid day visits to the service therefore saving on time and resources. Patients had the option of personal choice. Staff reported working smarter to help reduce wait times and provide better patient outcomes. Remote consultations were promoted, and data provided demonstrated 23% of outpatient appointments were virtual to help with efficiencies.

Managers monitored and took action to minimise missed appointments. The service's transformation programme for 2023, had four major focus areas; reducing outpatient follow-up, reduce waiting lists, reducing incidences of patients who do not attend (DNA) and improving advice and guidance performance. Staff monitored their performance and leaders had regular meetings to review progress and action plans.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff told us they had sensory products for patients who were anxious, for example, fidget toys to keep people distracted. Staff provided examples of innovative way of engaging anxious patients in advance of their appointment, for example, we were told of a patient living with a sensory condition being supported by their dog while attending their appointment.

Staff understood the additional needs of patients living with mental health conditions, learning disabilities and dementia. Patients received the necessary care to meet all their needs. For example, a nurse talked to us about scheduling people at quieter times to avoid sensory overload.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Interpreter and translation services were available. Posters were displayed in languages other than English. Information was displayed in the waiting area which explained the different types of scans the service offered and why they were used.

Staff had access to communication aids to help patients become partners in their care and treatment and translation services and hearing loops were available.

There was onsite parking, however it was a big site and disability parking was at a premium. People who used the service told us they could not always find a suitable parking space.

Access and flow

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 national standards.

Managers monitored waiting times. Patients could not always access services when needed and did not receive treatment within agreed timeframes and national targets. Patient delays and waiting times were on the service's risk registers, and staff were concerned about the impact of long waits. For example, concerns relating to outcomes for patients. In response to access and flow concerns, an outpatient transformation programme was developed. We looked at the trusts 2023/24 Outpatient Transformation Programme which outlined the pathway for how the service would drive improvement in increasing attendance and reducing the number of people who did not attend and follow-ups.

Outpatients

Clinical activity and waiting times were discussed by staff at clinical governance meetings. In oral health, staff recorded and discussed the 1108 patients who were waiting to be booked. In the outpatient eye clinic, patients waited 96-100 weeks plus. Staff also discussed the 18 week booking from referral to treatment time to look for ways to make improvements.

Managers were aware of the need to keep the number of cancelled appointments to a minimum. Managers from across the outpatient departments met regularly as teams to monitor and manage cancelled appointments. As part of the outpatient transformation programme, staff monitored outpatient 'do not attend' data. We looked at figures from December 2021 to September 2023 which demonstrated a reduction in people not attending planned appointments from 5.5% to 3.3%.

Staff used learning to improve the late running outpatient department clinics. Staff told us they understood the impact on patients and staff. Staff set up an evidence group to help monitor and manage late clinics. The head of patient safety collaborated with clinical staff to develop a standard operating procedure to help reduce the impact of clinics that ran later than 30 minutes.

Managers and staff worked to make sure patients did not stay longer than they needed to. Staff managed clinics by tracking patient arrivals and waits for clinics. Staff updated patients in the waiting area if there was a 30-minute delay in clinics. Staff told us they had seen benefits from auditing clinics and used evidence from incident reporting to restructure a clinic that always started late.

Staff took time to track patients who did not attend at 20 minutes post appointment time.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received.

Patients, relatives, and carers knew how to complain or raise concerns. Staff documented complaints and reviewed and monitored each complaint for responses and themes.

We looked at complaints data provided by the service from October 2022 to September 2023. The majority of all complaints received related to delays, cancellations and waiting times. Staff we spoke with told us that most of the concerns raised about the service were in relation to waiting times and cancelled appointments.

The service clearly displayed information about how to raise a concern in patient areas. Staff displayed the number of complaints received on their public quality boards in each patient waiting area.

Is the service well-led?

Requires Improvement 

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

Outpatients

Leadership

Leaders generally had the skills and abilities to run the service. They did not always understand and manage the priorities and issues the service faced. They were not always visible and approachable in the service for patients and staff. However, they supported staff to develop their skills and take on more senior roles.

Outpatients sat under the umbrella of separate divisions. The leadership structure for the outpatients department sat in these divisions. Managers and senior clinical staff led the daily running of the services.

Leaders did not understand all the challenges each service faced. For example, issues with faulty medicines fridges in oncology and furniture that was not compliant with safety standards in one of the eye clinics. Leaders were either unaware or slow to respond to the medicines safety issues. Staff mostly spoke highly of their first line managers and described them as visible, approachable, and knowledgeable. However, some staff told us they did not always see the senior leadership team and, in some departments, staff reported not seeing much of matrons in the day to day running of the service.

Leaders supported staff to develop their skills and take on more senior roles. Staff told us how they were supported to improve their competences and acquire additional qualifications. Staff were supported to develop their leadership skills with leadership courses available to those staff in leadership positions.

Vision and Strategy

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

The service had a clear purpose statement which was shared with people using various platforms. Posters, electronic messages, leaflets, and literature outlining the services vision and values were displayed throughout the service. Staff understood the vision and could explain each of the core values. The acronym PRIDE represented the service as being people-focused, looking after the safety and care of patients, carers, and colleagues. Respect to demonstrate care, compassion and kindness and value others' diverse needs. Integrity to uphold honest, open, and ethical approaches to everything they do. Dedication where they worked as one team to support each other to maintain the highest professional standards. Excellence to commit to continuous learning and improving to achieve the best outcomes for patients.

Leaders demonstrated forward planning in their five year planning strategies. Caring with PRIDE was a five year plan developed with staff, patients, carers and local partners. Staff held workshops, events and surveys and reported in their 2022 literature that they had over 1000 responses. The literature outlined their commitment to reducing waiting lists by for example expanding capacity. Leaders and staff from across the local health economy contributed to meetings across the service. Their contributions were documented in meeting minutes and other literature, for example, work with local educational and research institutions and other NHS trusts.

Leaders worked in an integrated way with the Integrated Care Board and reported having alliances with partners in improving health and wellbeing. Staff across the service gave examples of joint working and learning from colleagues from other local NHS hospitals. For example, staff on the outpatient forum told us they visited neighbouring hospitals to learn from what worked well in their outpatient departments. Staff on the outpatient forum also spoke of inviting colleagues from neighbouring NHS hospitals to join them in sharing good practice, issues and ideas at the outpatient forum. This was encouraged by senior leaders who also provided examples of alliances with the local health economy.

Outpatients

Leaders monitored their progress against the service's strategies. Managers met monthly to review progress against their strategy. The service took an open and transparent approach to sharing their strategies. The service strategy was openly available on the service's website. Easy to access using the search bar and each document clearly providing up to date information about setting out what they aimed to achieve across the service. For example, a strategy introducing their September 2023 Patient Safety Incident Response Framework (PSIRF) which was in line with the NHS Patient Safety strategy. Another strategy dated April 2023 was Caring with Pride strategy. This strategy set out their five-year plan to improve patient care and involved local people.

Culture

Staff did not always feel respected, supported and valued. Staff were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Leaders provided a people and culture strategy to support staff wellbeing. The strategy outlined the services ambition "Together, we will support each other to be the best that we can be, to be valued and proud of our hospital for all". Staff relayed that they felt supported, however this message was not consistent. For example, in one area where staff were significantly understaffed, staff worked outside their paid working hours to ensure they met the needs of patients. Staff shared that low banding made staff recruitment difficult. Leaders agreed an increase in banding to attract staff, however this had been a lengthy administrative process and caused delays in recruitment which impacted poorly on staff wellbeing.

Staff had opportunities for career development. Staff provided examples of when they had been encouraged to develop their skills, qualifications and advance in their careers. For example, some staff had been encouraged to advance their skills by completing advanced nurse practitioner qualifications. Leaders were supported in achieving leadership qualifications to support them in newly acquired leadership positions. Staff were allocated the time and finances to achieve their potential by gaining formal qualifications.

The service encouraged feedback from people who visited all areas and from staff. Feedback forms for patients and visitors to complete and their responses were displayed on boards in communal areas. Staff had personal development reviews and within that they were encouraged to share and resolve concerns. The service provided additional guidance and support to staff beyond their first line managers.

Staff could access a Freedom to Speak Up Guardian and Speak Up Champions whose role was to listen and support staff to speak up and have their voices heard.

A chaplaincy and counselling and support, and Schwartz Rounds (a forum for staff to support each other and reflect of the emotional impact of their work) and mindfulness classes were also provided to staff who needed extra support.

Vacancies and sickness impacted on staff wellbeing. Leaders in ophthalmology reported in August 2023 high levels of sickness and vacancies which impacted on staff morale. Staff recorded concerns in relation to using bank nurses frequently. Leaders used regular bank staff who were familiar with the services where possible. Leaders recorded use of locum staff as a challenge in relation to delays in eye clinics.

Governance

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

Outpatients

The service had a clear governance structure with key lines of accountability and responsibility. The structure of meetings and committees ensured information flowed from service level through to the board of directors and back down to the service. The governance structure in place provided assurance of oversight and performance against safety measures. For example, staff attended divisional monthly clinical governance meetings. Membership was wide and involved staff from across departments including governance leads and facilitators. Items on the agenda included patient safety incidents, risks (including progress against risks), complaints, and quality and performance.

The service held joint directorate clinical governance meetings and divisional clinical governance meetings. We reviewed divisional board meeting minutes (July 2023) for example, medicine board meeting. Staff in attendance discussed key patient quality and safety issues. Areas covered included learning and response times to serious, serious incidents identified for sharing, safety incidents and themes, duty of candour and patient experience feedback including complaints and risk register and staffing.

Directorate meetings were held monthly online for inclusion and attendance. Minutes from meetings demonstrated discussions around risk management, staffing concerns, mandatory training and appraisal compliance, sickness, and vacancies. Audits were discussed, reviewed, and learning shared. For example, actions for sharing information with staff to better understand patient initiated follow up and when to use it.

The service provided us with their outpatient transformation programme for 2023. The programme was managed and overseen by a fortnightly governance meeting and chaired by the Deputy Chief Operating Officer. The meeting was attended by divisional leaders, operational management as well as the Transformation team members aligned directly to the delivery of the Service wide ambitions. There were four major focus areas; reducing outpatient follow-up, reduce waiting lists, reduce do not attend (DNA) and improving advice and guidance performance. Staff monitored performance using an electronic dashboard for visibility and transparency.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The service had local risk registers which were monitored, updated regularly, and shared with the senior leadership team and the board. Risks were discussed at various meetings feeding into monthly operational board meetings. Each risk was scored, had a review date, control measures in place and a risk owner assigned. The service had 66 risks on the risk register. All high scoring risks had been reviewed and had action plans in place.

The service had processes and procedures in place to discuss learning from incidents. This included daily safety huddles, team meetings, operational board meetings and were escalated through to a variety of quality meetings. Leaders told us there was a good reporting culture.

Leaders used initiatives to raise awareness of incidents. For example, shared learning from incidents in the ‘Learning Zone’.

There was an audit programme across the services. Poor compliance outcomes prompted action plans for improvement. Leaders facilitated and encouraged staff to share ideas to benefit staff and people who used the service. Quality and safety performance data was displayed on notice boards and updated regularly with up-to-date results of audits and surveys.

Outpatients

Information Management

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

The service collected reliable data and analysed it. For example, monitoring compliance with; surgical safety checklist, hand hygiene, use of personal protective equipment and medicines management. The information systems were integrated and secure.

A new patient electronic record system was in process but had not been fully implemented at the time of our inspection. Records were a combination of electronic and paper. Not all patient records were stored safely or in line with up-to-date guidance. Electronic records and digital information were kept on computers that were secured with usernames and passwords for each member of staff preventing unauthorised access. However, staff did not always follow service guidance by logging out of computers when not in use.

Leaders ensured information was provided in easily accessible formats to ease understanding of performance.

Engagement

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

Staff attended an outpatients forum as an opportunity to learn from each other about outpatient department concerns and developments. Staff told us they valued the opportunity to work together sharing learning and challenges at the outpatients forum. The service's monthly newsletter had a two-page patient experience section. The newsletter shared how patients and their families were and could be involved in the services. The newsletter provided a QR code giving further information to people who wanted more engagement.

Leaders told us they engaged regularly with local NHS hospitals and health and social care providers. The service worked as an Integrated Care Systems (ICSs). ICSs were partnerships of organisations working together to plan and deliver joined up health and care services to improve the lives of people in their area. Examples of joint working for example with local hospitals were responding to covid and reducing treatment waiting lists by sharing resources.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service was involved in a number of sustainability initiatives to improve care and treatment of patients. The service entered into a national video consultation pilot with NHS England/Improvement in early 2020 as part of the National Outpatient Programme which continued in to 2023. The service offered virtual appointments as an option to provide flexibility, reduce traffic, costs and help to reduce cancellations for those who could not attend. Staff used technology to help patients access digital appointments and patient letters. Paper communication remained an option for those with a preference for letters in the post.

Staff engaged with fundraising and charity organisations and events to raise funds to support patients for example in the outpatient oncology department.

Outpatients

Staff encouraged each other to be innovative and improve for the benefit of patients. Staff received certificates and vouchers for their contributions to improvements. Staff awards and nominations from patients were encouraged. We saw an example of staff innovation being awarded and inspired by an improved patient experience. Staff arranged for an anxious patient living with autism to bring their dog to attend their appointment. Staff received written thanks from the patient's parent for the innovative way they supported the patient.

Surgery

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

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

Mandatory training

The service provided mandatory training in key skills to all staff but not all medical staff completed it.

The mandatory training (MT) was comprehensive and met the needs of patients and staff. Staff were required to complete 12 modules at varying levels dependent on their role and position. Subjects included fire safety, mental capacity (MCA) & Deprivation of Liberty safeguards (DoLS) and safeguarding.

During our last inspection, data provided by the trust showed compliance levels fell below the required target of 90% for just over half of the nursing and medical staff training modules. During this inspection we found that nursing training compliance had improved but medical staffing had declined.

We reviewed current data provided by the trust for staff within the surgery division. The overall compliance rate for all staff was 92.4% against the trust target of 90%. Overall compliance rates for medical staff was 83.3%, and for nursing staff was 94.1%.

Training completion rates for medical staff varied between 75.3% for adult basic life support and 91% for information governance.

We spoke with 2 junior doctors who stated they were up to date with their MT but had completed this in their own time as they were too busy to complete this during their working hours. They believed they had completed level 3 training for safeguarding but were unsure. They felt confident to raise safeguarding concerns to the nurse in charge following the training.

Data showed that nursing staff had met the trust target for 11 of the 12 modules. Compliance varied from 83.2% in moving and handling to 99% in Equality, Diversity and Human Rights. This was much improved since the last inspection where compliance was only found in half of all MT modules.

Nursing MT completion rates were monitored by either ward managers or clinical educators on every ward. On Easton ward the ward manager printed off the electronic dashboard and displayed the ward's compliance for the month. Clinical educators had oversight of training and induction for all nursing staff on the ward and would offer training to staff in response to incidents or learning that was identified during supervision. Nursing staff reported it could be difficult to complete MT but were encouraged and supported by the clinical educators and senior nurses to attend. Senior matrons would feed MT compliance to the divisional board through governance meetings.

We spoke to an agency nurse during the inspection who had worked for the trust since March 2021, they reported having an agency trust induction and demonstrated good knowledge around MCA and safeguarding.

Senior matrons reported that training was being offered to teams to improve attendance as well as Datix themed training sessions. They were aware that there was a large proportion of staff waiting to book onto courses as well as a percentage of staff that did not attend their booked face to face training. For example, for BLS there was a utilisation of 60% for face-to-face training. This was addressed by overbooking to ensure that the trust were making good use of the resources available. Senior matrons reported that training was cancelled at times due to staffing but were not aware of this occurring recently.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All ward areas were visibly clean and well-maintained. Wards and theatres were cleaned regularly by the trust employed housekeepers, floors were cleaned by domestics and deep clinical cleans were contracted to a private company. We saw disposable curtains in use within bays with dates displayed when they were changed on all expect one ward.

Cleaning records were up to date and demonstrated that areas were cleaned regularly. Infection prevention control (IPC) audits were carried out and results were displayed at the entrance of each ward. We spoke to one housekeeper who was very proud of the ward infection prevention control audit scoring 100%. We reviewed the last 3 months audit dashboard data for the division, the score for IPC audit was above 98%.

Green 'I am clean' stickers were dated, timed and placed on equipment after cleaning on all surgical wards. Theatres used tags to demonstrate equipment had been cleaned. We checked 5 pieces of equipment, all had tags stating the date and member of staff that had cleaned the item.

Hand sanitiser gel was placed at the entrance of every ward and around clinical areas. There were adequate personal protective equipment and hand washing facilities on all wards and theatres.

Staff worked effectively to prevent, identify, and treat surgical site infections. The trust screened patients for methicillin-resistant staphylococcus aureus (MRSA) and carbapenemase-producing Enterobacteriaceae (CPE) on admission or at pre-assessment clinic. We reviewed 19 patient records and all had documented screening for COVID-19, MRSA and CPE on admission. Infection control was monitored and documented within personalised plans of care proforma with a documentation box to record the date of the next MRSA screen.

We reviewed the division's last 3 IPC audit results from July 2023 to September 2023. Data demonstrated a compliance score of over 95% for the surgical wards every month.

The clinical sterile services department (CSSD) were an internal team who ensured that theatre equipment was clean, sterilised and returned on time. Staff members told us that if they required anything urgently, they could phone the CSSD and they were very helpful.

Nursing staff received and kept up to date with training in Infection Prevention and Control - Level 2 with an overall compliance of 96.1% within surgery. Medical and dental staff received training in Infection Prevention and Control - Level 2 but did not always keep this up to date.

Surgery

Environment and equipment

The design and use of premises generally kept people safe. Staff managed clinical waste. However, the service did not always maintain or store equipment suitably.

The layout of all the surgical wards was identical which allowed staff and visitors to orientate themselves easily. Wards were accessed by staff using swipe access and intercom entry for all visitors. The design of the environment followed national guidance. For example, all areas had single sex bays, window restrictors were in place and wards had dedicated patient toilets. Across all wards the treatment rooms were being used to accommodate additional escalation beds to meet the demand of admissions. This had an impact on the storage facilities.

Patients could reach call bells, but staff did not always respond quickly when called. Patients reported that staff would come to check on them regularly and at times had to wait for assistance. Emergency and call bell checks were carried out weekly for the division. The compliance rate for the division during September 2023 was 95.28%.

Staff generally carried out daily safety checks of specialist equipment, however, there was not an effective system in place to ensure that equipment was serviced in line with manufacturer recommendations. During inspection we reviewed the resuscitation trolley on 3 wards. Daily checks were completed and all equipment was in date. However, one sepsis 6 bag had not been checked since July 2023. This was escalated to the nurse in charge who checked the bag immediately. We reviewed a variety of equipment such as portable suction units, blood pressure machines, manual handling equipment and bladder scanners across 7 wards and found 10 out of 34 were overdue their testing or servicing. There were 3 portable vital signs monitoring machines that were due testing in June and August 2023 and 2 bladder scanners which were dated as needing a review in August 2023 on Edgefield ward.

Theatre staff informed us that equipment servicing was carried out by onsite medical engineering department who kept a list of all equipment in the theatre department. There was an equipment lead for theatre who assisted with reporting of damaged equipment and ordering of new equipment. Within theatres, 14 pieces of equipment were checked, 13 were all serviced and had stickers which showed when servicing was next due. Within theatre 13 a light was overdue a service, when staff were asked they reported that the equipment belonged to ear, nose and throat services and therefore did not know about its servicing. This was escalated to the matron during the inspection and staff were reminded to report any overdue servicing to equipment.

There was a lack of storage for larger pieces of equipment on Gissing ward and resulted in chairs and manual handling equipment being stored outside bays. This meant that ward areas were cluttered and restricted access when transferring patients on beds. We observed limited equipment storage for 2 theatre suites which resulted in equipment being stored along the corridor.

The team leader for acute theatres reported that disposable equipment such as implants would be replenished following use. Items were scanned and automatically ordered to reduce overstocking or not having required stock and felt this system worked well.

Theatres storage rooms appeared visibly clean and tidy with equipment stored on shelves available.

A monthly procurement meeting was attended by the sterilisation lead, equipment lead matron, and 2 material management staff to discuss improvements, changes and challenges.

Emergency assessment admission unit did not have an anti-ligature room. The ward manager informed us that this was on the risk register as there was no room available for at risk mental health patients awaiting surgery. A room on Easton ward could be used if required to mitigate risk.

The service had enough equipment to help them to care for patients. A staff nurse on Easton ward told us they had access to all equipment required to carry out care such as bladder scanners, ECG and manual handling devices. Specialist equipment such as air mattresses and cushions could be ordered by phone and it would come within a few hours or the next day.

In 2021 a National Patient Safety Alert was issued by NHS England and NHS Improvement National Patient Safety team asking all providers that used piped medical air to eliminate the risk of inadvertently connecting patient to medical air via a flowmeter instead of oxygen. We reviewed these ports on 2 wards and they were capped off in all bays in accordance with the national guidance.

Staff disposed of clinical waste safely. Sharps bins were provided on all wards to allow staff to safely dispose of needles or sharp equipment. Sharps bins should have the date and signature of the person that assembled them. During inspection we found not all sharps bins were labelled in accordance with this standard. Clinical and non-clinical bins were in bays and side rooms to allow for appropriate disposal of waste.

Assessing and responding to patient risk

Staff completed risk assessments for each patient on admission and removed or minimised risks. However, staff did not always update or evidence they acted upon patients at risk of deterioration.

Risk assessments were completed for falls, pressure ulcer, nutrition, and bed rails within 6 hours of admission and these were reviewed and updated in line with policy or when there was a change in condition. During inspection we found that staff did not always update or evidence they had acted upon risk, for example we found nutrition reviews were overdue, a falls risk assessment was not completed following a fall and a mental health risk assessment was not evident for a patient who had a history of mental health concerns.

Pressure ulcer risk was assessed and documented using the Pressure Ulcer Risk Primary or Secondary Evaluation Tool (Purpose T). This framework is a traffic light system to make a distinction between primary prevention (applicable to those at risk of pressure ulcer development), and secondary prevention (applicable to those who already have a pressure ulcer). We reviewed 10 sets of records; all risk assessments were completed and reviewed in line with policy for all 10 patients.

'MUST' is a 5-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan. It is for use in hospitals, community and other care settings. We reviewed 10 sets of notes for completion and ongoing review of individual's MUST as per documentation. We found all 10 were completed on admission, 2 were not reviewed within the date specified on the personalised plans of care daily record.

Staff were required to complete the World Health Organisation (WHO) 5 steps to safer surgery checklist. The Safer Surgery Saves Lives initiative was launched by the World Health Organisation (WHO) in 2008 to reduce the number of surgical errors and enhance patient safety during the perioperative phase of their care. The launch saw the introduction

of a surgical safety checklist. The 5 Steps to Safer Surgery was introduced in 2010. It is a process for improving the way theatre teams communicate with each other. It consists of 5 steps and the WHO surgical safety checklist form 3 of the 5 steps. During inspection we reviewed 9 patient's surgical notes to review completion of the WHO checklist, 6 were fully completed.

We reviewed the trust WHO audits from July 2023 to September 2023. Overall audit data showed that there was a small decline every month in the compliance of WHO checklist. We found that in July 2 WHO checklists were not documented/ completed fully within Ophthalmology. In August a whole section of the WHO sign out was not completed for 3 patients within Trauma & Orthopaedics (T&O), Ophthalmology and Gynaecology specialities. In September there were 18 incomplete WHO checklists across 7 specialities. The division planned to remind all staff of their responsibility to comply with the completion. This would be communicated through speciality team meetings and monitored. There were 2 never events reported relating to a lack of WHO safety checks being carried out in July 2023 and August 2023. We were not assured that risks were mitigated to reduce avoidable harm.

During the inspection, we followed an elective and acute patient through their patient journey reviewing against the 5 steps to safer surgery guidance. For both patients the 5 steps were adhered to with clear communication and handover observed upon transfer to the ward.

We observed the management of accountable items for 2 patients, this process ensured patients were not at risk of retained items following surgery. Accountable items were checked and counted for prior to surgery and at every layer closure in line with WHO accountable items guidance.

Electronic flagging alerts were applied to patient's electronic records to highlight vitally important clinical, social or safety factors that needed to be considered for individual patients. These were denoted by an exclamation mark symbol when identification bands were printed. During the inspection, a patient had this alert symbol when they were transferred to theatre for their surgery. Multiple ward and theatre staff were unable to state what this alert symbol was. Senior leaders were informed of this following the inspection. They told us that they would ensure this was communicated to all staff to ensure patients were kept safe.

Staff used a nationally recognised tool to identify patients at risk of deterioration. Staff used the NEWS2 tool and updated patient records in line with their NEWS score's monitoring frequency. The NEWS2 escalation process was available for staff to refer to electronically. Staff did not always follow trust guidance for the use of NEWS2. We reviewed 10 patient records, of these 3 patients had a change in NEWS2 of more than 3 where escalation and increased monitoring frequency is recommended. Upon review, trust guidance had only been followed in 1 of the 3 patients. A junior nurse was unable to state when to escalate a change in NEWS2 score. Another nurse reported that if there was a change of NEWS2 score of more than 3 in one parameter they would escalate this via the trust Alertive system and document this within the patient's notes. They demonstrated a good understanding of the trust guidance.

Escalation of a change in NEWS2 requiring a medical review was via the hospital Alertive system which informed the multidisciplinary team, at night the hospital coordinator would delegate the medical review to a medical doctor. Any escalation through Alertive should be clearly documented within patient notes as the Alertive system was not considered to be a documentation tool for care. This was not found to be consistent when we reviewed patient records. For example, of the 2 records reviewed on Gateley ward, escalation had been documented in 1 set of notes.

In recovery, there was a system in place to ensure that observations with a NEWS 2 score was recorded prior to transfer to the ward.

Surgery

During the inspection, a patient on Dilham ward had deteriorated whilst sat out in a chair. They stated that ward staff had acted quickly. Records showed hourly observations were completed as recommended by the medics and the patient was stable.

On admission all patients were risk assessed for needing pharmacological venous thromboembolism (VTE) prophylaxis. The national risk assessment tool was integrated with the Electronic Prescribing and Medicines Administration (EPMA) prescribing system. The system was configured so that a risk assessment must be completed before prescribing could be accessed.

We reviewed EPMA record for 14 patients', 10 were identified as requiring pharmacological VTE prophylaxis and were started as soon as possible and within 14 hours of hospital admission in line with national institute for health and care excellence (NICE) guidelines. We found, 5 patients required a review of their risk assessment, and this was evidenced in 4 patients within EPMA and medical notes. We reviewed the trust guidance 'Summarising the General Principles of the Prevention of Venous Thromboembolism (VTE) in Adult Patients'. We found that 8 surgical patients did not have their VTE risk reassessed in line with trust policy at 24 hours.

VTE risk was reviewed at pre-admission clinic with a review for changes on admission. During inspection we reviewed 9 day-case patient care records on Nelson ward. We found only 2 patient records had a VTE risk assessment completed as per trust policy.

The trust audited 5 types of VTE risk assessment. Results for their audit from July 2023 to September 2023 for a total of 8,562 admissions under surgery showed an overall completion rate of 80% within 24 hours (included on admission, at 24hrs and pre-admit), with 68% being completed on admission. This meant that 20% of patients did not have a VTE risk assessment completed.

During our previous inspection temperature measurements of adults in surgery was carried out randomly and at the anaesthetist's discretion. This meant patients were not monitored enough to ensure they had no adverse reactions post-procedure. We observed and reviewed the care records of 3 patients within the post anaesthesia care unit (PACU) during inspection. All 3 patients had temperature recorded and warming blankets were provided for 2 patients. We were assured through observation and record review that patients were being monitored in accordance with the NICE hypothermia guidelines.

The trust did not have a process or policy in place to assess for mental health risk where indicated upon admission to a surgical ward. An inpatient mental health risk screen pilot had commenced to trial a document for 3 months in selected inpatient areas which would conclude in November 2023. We reviewed the mental health risk assessment tool being trialled, it listed risks which were RAG rated gave guidance on the level of observation to be implemented.

Within the personalised plans of care, there was an assessment prompt for mental state which prompted staff to review for confusion, anxiety, mood and learning disability. This was completed within the 10 patient care records we reviewed. Staff we spoke to were able to demonstrate an understanding of the process to refer patients to the mental health liaison team.

There was no anti ligature room on the emergency surgical assessment unit (EAUS), this was evidenced on the risk register. Bespoke training was offered to staff providing 1 to 1 care for patients at risk of self-harm. There were also mental health trained support workers on the bank if required. Risk was further mitigated using an anti-ligature room on Easton ward.

Surgery

During the inspection, we asked staff on 6 surgical wards if they had ligature cutters on the ward. Five ward managers reported not having ligature cutters on the ward and the ward sister on Denton ward reported large scissors were stored in the resus trolley. We asked 4 members of staff the location of the ligature cutters and none were able to state where they would access them if required. This was fed back to the senior leaders during inspection. Following inspection senior matrons reported that ligature cutters were situated on every ward at the time of the inspection within the resus trolley. We were not assured that staff had knowledge of how to access and locate ligature cutters if they required them.

We reviewed a patient's care record from 26 July 2023. There was evidence of nursing escalation to the nurse in charge and timely referral to the safeguarding team. There was good evidence of multidisciplinary working to address safeguarding concerns and timely review from the psychiatric team whilst the patient was an inpatient. Medical reviews were documented daily with a clear plan. This meant there was effective communication between healthcare professionals and needs were met.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. We observed a morning handover on Gissing ward. Nurses and HCA staff discussed each patient, changes overnight and plans of care for the day were explained. During inspection we observed the handover of care from theatre to the post anaesthetic care unit (PACU), both scrub nurse and anaesthetist handed over all the care provided in theatre to the PACU nurse. During transfer to the ward a full handover of the care given in theatre and PACU was summarised to the ward nurse. Information given included blood loss, allergies, concerns, equipment required. This meant that the nurse taking over the patient's care had all the information needed to deliver the continuity of care.

Nurse staffing

The service did not have enough nursing and support staff. However, managers regularly reviewed and adjusted staffing levels and skill mix. This included the use of bank and agency staff who had a full induction.

The service had enough nursing and support staff to keep patients safe with the use of agency and bank. The service used the safecare system tool which aligned nurse staffing with patient acuity. Ward managers adjusted staffing levels daily according to the needs of patients. Staffing was reviewed 3 times daily; shortages were flagged to matron.

Display boards were observed outside all wards with information for planned and actual staffing numbers for the day. All wards had the number of nurses and support staff on shift displayed so that patients and visitors were informed. We found that on 3 wards there was at least one registered nurse (RN) less than planned for. On Gateley ward there was 50% less staff than planned for. During the inspection we observed staff being moved to other wards to cover vacant shifts.

The number of nurses and healthcare assistants did not match those planned. We reviewed the last 3 months of planned versus actual data and found that they were able to meet the overall demand by 92%, with the division being able to staff RN shifts at an average rate of 95% and unqualified at 90%. Gissing ward had an average of 89% RN and 76% of unqualified staff against their planned rota. This meant that there was a shortfall of staff to meet the needs of the patients which was met through redeployment of staff from other wards.

We reviewed the red flag data which related to staff being redeployed to other wards to cover staffing shortages for the last 3 months from July 2023 to September 2023. A total of 393 staff were moved from surgical wards or the emergency

department to cover staffing within the Surgery and Critical and Emergency Care (SCEC) division to maintain safe staffing levels. Of these, 74 were trust nurses and 98 were health care assistant (HCA), with the highest number of staff being moved from Denton ward. These staff were moved within specialty, it meant they had knowledge of local trust policies and procedures.

Following the staff survey, staff within the division had identified areas they wanted to see improvement, one of which was understanding and reduced redeployment. Senior leaders reassured us they only moved staff when required to meet the acuity of patients and where possible would use agency staff to reduce the impact on their employed staff.

At core service level, for surgery staff the sickness rate was 4.4% in June 2023. Sickness rates were monitored by ward managers, and the division had a workforce board to address sickness rates and improve well-being of staff. A ward manager told us they had a high sickness rate for HCA and felt the budgeted staffing plan did not meet the needs of the patients. A RN told us that they regularly were responsible for the care of 10 patients which they felt was unsafe. Matrons were supportive of booking agency to cover vacant shifts to ensure that they had the right staff to keep patients safe.

During inspection we saw agency staff working on wards. We spoke to an agency nurse during the inspection who had worked for the trust since March 2021, they reported having an agency trust induction and shifts were block booked. This meant they were working on wards and staff they were familiar with.

For the surgery core service, the trust had 33.18 full time equivalent (FTE) leavers in June 2023 (latest available data) which decreased from the previous month (43.37 FTE in May 2023).

We reviewed the current staffing data within the SCEC division following inspection. There were variance in vacancies for most bands with the exception of band 3, 4 and 8b against the budgeted establishment. The largest vacancies were within band 2, band 5 and band 6 at 62.95, 78.70 and 24.06 whole time equivalent (WTE). This meant that there was a lack of healthcare assistants (HCA) and qualified nurses across the division. The trust flagged worse than expected for the turnover rate for Healthcare Assistants at 22.9% compared with the sector average of 13%. Healthcare Assistants have had consistently worse than expected turnover rates for the last 12 months, ranging from 9.5-12.2% above the sector average. Leaders reported carrying out well-being checks on wards every Talk Tuesdays to discuss concerns and having a bespoke mental health service for their staff to help retain staff. These were initiatives implemented to retain staff.

Senior leaders reported that they had worked hard to address the vacancies within nursing through an international recruitment process with 22 staff being recuited. Over the last 18 months the vacancy rate had improved from 50% to less than 5% with a retention rate of 9% for the trust. Staff reported that although the trust had worked hard to address the high vacancy at lower grades there remained a shortfall in higher banded nurses with more clinical experience.

We reviewed the staffing allocation board in 7 theatres during the inspection. All specialities had the recommended staffing in line with recommendations by the nursing and midwifery council (NMC). A matron reported that they covered sickness by offering overtime to staff or used agency. The trust tried to use the same agency staff where possible to ensure they were aware of local policies, procedures and knew staff members to reduce risk.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Surgery

The service did not have enough medical staff to keep patients safe. We reviewed the current medical staffing for the division. The highest vacancy was within staff grade practitioner with only 1 whole time equivalent (WTE) in post compared to a budget of 9.7 WTE. Vacancies were also within associate specialist, hospital practitioner and foundation programme level 2.

We requested data to review planned versus actual number of medical staff over the last 3 months. This data was not in a format that provided assurance that staffing levels kept patients safe.

Records

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

Patient's notes were not always comprehensive, but all staff could access them easily. We reviewed 20 sets of patient's notes during inspection, 10 within day surgery unit and 10 on the wards. Records were not stored securely on wards and not completed fully in accordance to trust policy. For example, nutrition assessments were not completed at due dates, Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms were either partially or not completed, and escalation of deterioration was not always clearly documented in patient records.

ReSPECT forms replaced existing documentation of CPR status. The trust carried out audits to ensure that ReSPECT processes were robustly adhered to as per trust policy. The results were reported to the surgical division clinical governance and service directors meeting committee. We looked at audit data from June 2023 to September 2023 which demonstrated an average completion of 64% and 25% not completed. During the inspection, we reviewed a total of 22 ReSPECT forms across the surgical wards and found 11 (50%) were not completed in line with trust policy.

We reviewed EAUS band 6 meeting notes held in April 2023. A ward-based ReSPECT audit had been completed and showed a compliance of 67%. Ward manager encouraged nurses to remind consultants to countersign them as this had been agreed at the last governance meeting to improve completion rates. This showed that the wards were reviewing and trying to improve their performance.

We reviewed a patient's record who had fallen and hit her head, the medical team had prescribed neurological observations for 48 hours. There was a 12-hour gap in observations overnight where they had not been carried out. There was no documentation in the notes to advise why these had not been carried out by staff on the ward.

We reviewed a patient record for evidence of contemporaneous record keeping of risk and care. We found that risk assessments and ReSPECT forms were competed on admission. However, a post fall risk assessment was not completed in line with policy. A mental capacity assessment (MCA) and deprivation of liberty (DOLs) was completed and in the records on 26 September 2023.

Following the inspection, we reviewed a patient record for their admission on EAUS on 26 July 2023. We found that nursing, medical and staff entries were not always completed with the date and time as per trust policy, ReSPECT form and self-discharge form were incomplete, and the MUST risk assessment was not fully completed or signed.

Medicines

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

Surgery

Staff did not follow systems and processes when safely prescribing, administering, recording, and storing medicines. We found that medicines management did not comply with trust policy on 4 of the 6 wards we visited during inspection. We were informed of a serious incident on a ward due to missed medication administration resulting in moderate harm.

We reviewed the storage of controlled drugs (CDs) on the wards. We found all wards had a separate room to store medications which had keycode access. Wall mounted lockable controlled drug (CD) cupboard in line with the regulations in the Misuse of Drugs (Safe Custody) Regulations. Keys to access the CD cupboard were held by the nurse in charge, however medicines were not always recorded and stored in accordance to trust policy. For example, CDs were not always documented correctly in the register and bulk fluids were not locked away.

During our previous inspection we found that where CD checks were carried out, nurses failed to record the quantity and patient's own CDs were kept with the ward stock, despite the nursing and midwifery council's (NMC) standards for medicine management guidelines stating they need to be segregated.

The service checked CDs weekly. Separation of ward and patient's own CDs was achieved through placing patient own CDs in a green basket, the separation was impacted upon when CD cupboards were full of medication. For example, on Gissing ward, medications for the high dependency unit were stored with the rest of the ward resulting in baskets being pushed to the back on shelves and staff not being able to access medications quickly.

On EAUS we found that all ward CDs were recorded in line with policy and guidance, however patient's own CDs were not destroyed or transferred with patients when they left the ward. For example, we found a dosette box for a patient who had been transferred to Docking ward the day before, and medications for 2 others that had been discharged from the ward over 11 days ago. The CD record book showed 70ml of medication being stored but we found only 20ml was present. This patient had been discharged on 16 August 2023. Fluids had recently been moved to another room which was not securely locked. We were informed that a lock had been ordered.

We found a total of 8 patient's own CDs across 4 of the 6 wards we inspected after they had been discharged. We found 2 medications not locked securely as per trust guidance and 1 incorrect record on the contents page. We did not find any errors in the ward CD stock records books for all 6 wards.

We checked the drugs fridge and room temperature recording on all wards for the last 3 months. This was completed by the housekeeper on each ward. We found 2 of the 6 wards did not have daily temperature records in line with trust policy. During the inspection, on Dilham ward the fridge temperature was recorded as out of range for the last 3 days. This was escalated by the housekeeper.

The service used an electronic prescribing and medications administration (EPMA) system. Allergies were recorded within the EPMA system and where drugs were not administered nurses were able to document reasons for this.

We reviewed 15 prescriptions on EPMA to review for good prescribing practice in line with trust policy. We found that 14 had allergies checked and documented, 11 had accurate or updated weight documented and there were no gaps in administration that had not been documented against. This meant that not all prescription charts were in accordance with trust policy.

At this inspection we were told that there had been 3 medicines related incidents since February 2023 on Gissing ward due to medication being wrongly administered, given to the wrong patient, and given twice in error. Following the

inspection, the trust sent incident data relating to medicines management. In the last 3 months, there had been a total of 145 medicines management incidents, 57 in July 2023, 45 in August 2023 and 43 in September 2023. Any themes or changes made as a result of learning was not summarised within the data. We were not assured that staff used systems and processes to safely prescribe and administer medicines.

Medicines management audits were carried out every 3 months, results were shared with the medicines management group. In May 2023, overall compliance was 84% with the lowest score in relation to medication not locked away in drug rooms on 5 wards. We observed 2 medications not locked away on Denton during inspection. The audit demonstrated that Denton ward was the worst performing ward with 7 out of 10 audit questions not complied with. Actions taken following the last audit were not provided. On EAUS, all medication incidents were to be assigned to 1 nurse for review. This way the nurse could highlight a theme in incidents and also highlight if a member of staff was making multiple errors.

Incidents

The service reviewed patient safety incidents. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented, however, they were not always monitored.

We requested data from the trust following the inspection which showed over the last 6 months there had been a total of 4,098 incidents reported within the SCEC division, with the highest number reported in July (761) and the lowest in April (628). There was a total of 21 serious incidents (SIs) with 9 reported in June 2023.

Staff raised concerns and reported incidents and near misses in line with trust policy. Incident reporting was electronically completed by staff, staff we spoke to reported they felt confident completing an incident form.

Ward managers monitored the number of incidents reported on the ward and displayed these on information boards for staff and visitors. On Easton ward we were informed they had 30 outstanding incidents which were waiting for doctors to review and 5 for the ward manager to review. This meant that trust target for resolving reported incidents within 14 days was not always met.

A staff nurse reported they would receive feedback on incidents they had reported through the monthly team meetings. They reported that recently the trust had changed the ointment used in the management of grade 4 pressure ulcers as a result of learning through incident reporting.

Staff met to discuss the feedback and look at improvements to patient care. Within theatres serious incidents were discussed with those involved in a debrief meeting and all staff were encouraged to identify changes in practice to prevent reoccurrence. For example, a new change in practice for skin markings that had been implemented had been suggested by a theatre support worker. Incidents were also summarised in the monthly newsletter that was sent to all staff should they not be present at the monthly staff meeting.

Oversight of incidents within specialties was evidenced within sub board governance meeting minutes. Updates on SIs discussed at the serious incident group (SIG) meeting was fed back and a presentation in May reviewed the number of Datix closed over the last 12 months. This showed that there was regular oversight of incidents within specialties. Ophthalmology did not have a clinical governance lead for the last 6 months but the trust were able to share sub board meeting meetings where there was monthly review of ophthalmology incidents. Learning from incidents was not evident in the meeting minutes that we reviewed.

Surgery

Staff understood the duty of candour (DoC). They were open and transparent and gave patients and families a full explanation if and when things went wrong. During the inspection we saw evidence in a patient's record that DoC was applied as there was delayed wound care. We reviewed 6 root cause analysis (RCA) reports for SIs and never events, all of which had documented DoC evidenced within them.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations and evidenced in reports. Of the RCA reports reviewed, each looked at notable practice, contributing factors, identified root causes and lessons learned. It identified arrangements for shared learning and those responsible for the oversight of the recommended actions. There was evidence that changes had been made as a result of feedback. For example, during inspection a trolley with specialist bariatric equipment in theatres was present which was identified in a root cause analysis report in June 2023. We reviewed the clinical guidelines for anaesthetic management of the bariatric patient and guidelines all of which were within the action plan. However, we did not see evidence of audits to ensure that the new processes were embedded. For example, the trust did not audit the new process of marking skin on both sides of the hand following an incident.

The Recognise & Respond team had implemented 'DATIX themed learning' for all staff to attend on the first Monday of every month. These allowed staff to role play care actions and allowed staff to practice those newly found skills in a safe environment without pressure of having a patient in front of them. Feedback on these monthly sessions was positive. Over 50 staff attended the last session including students, nurses and junior medical staff.

Is the service effective?

Inspected but not rated

We inspected but did not rate effective.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. We observed staff asking patients if they were in pain whilst observations were being carried out. We saw patients receiving pain management in a number of ways including patient-controlled analgesia.

We reviewed a care record for a patient that had been discharged which demonstrated staff referring to the pain management team.

Staff prescribed, administered, and recorded pain relief accurately. Medicine prescriptions records we reviewed showed staff prescribed appropriate pain-relieving medicines at regular intervals during the day and extra medicines for any breakthrough pain.

Competent staff

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

Surgery

Staff were competent for their roles and had the right skills and knowledge to meet the needs of patients. However, staff were not always experienced. Senior matrons acknowledged this shortfall in senior nurses and told us that junior staff are supported to develop skills to allow for successful promotion. This was supported by practice development nurses and a junior nurse told us she was supported to take on more senior roles to develop.

Each ward had a clinical educator that had oversight of training and development for all new staff. New staff were supernumerary for 6 weeks whilst completing a 2-week trust induction and speciality specific training. The aim was to give all new starters a positive experience and offer supportive preceptorship. Staff told us they had regular supervision with their seniors and were supported to further career development. For example, a ward manager reported having regular meetings with the matron and had asked for meetings with the new matron which had been agreed.

A band 6 nurse on EAUS told us that she had recently completed personal development review training and would now be able to support in supervising HCA staff. Appraisal compliance was displayed in the staff room and was 98.6% at the time of inspection. This meant that staff had timely appraisals to support learning an development.

Each ward had their own clinical educators to support the learning and development of nursing staff. The clinical educators focussed training in response to learning and themes identified through incidents and developed an induction program to support new starters. A practice development nurse stated they had worked for the trust for 12 years starting as a healthcare assistant and completed a work-based learning course to qualify as a registered nurse. They had been in post as a practice development nurse for 5 years and was passionate about providing support for staff to develop their skills and further their career.

Multidisciplinary working

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

Daily red to green meetings were held on wards to reduce internal and external delays in care. We observed a red to green meeting with a therapist, discharge coordinator and nurse in charge. Ward staff reported the medical team did not attend these meetings, and this had an impact on timely discharges, such as delayed prescriptions and discharge paperwork. We observed effective communication and sharing of information to ensure patient centred care was delivered.

Health promotion

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

The service had recently been awarded funding for a 6-month trial of a prehabilitation practitioner. During the inspection, the matron for pre assessment shared a leaflet that would be given to patients on a waiting list for surgery. It looked at supporting patients in areas such as diet and nutrition and fitness to encourage and promote a healthy lifestyle whilst awaiting surgery. Patients would be able to access key information and ask for advice and referral to the prehabilitation practitioner who could refer to services, tailor an exercise programme and provide support and feedback to the consultant on progress made whilst awaiting surgery.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Surgery

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. On Docking ward, there was a patient that had a completed mental capacity act (MCA) and deprivation of liberty safeguards (DoLS) in the notes due to an onset of acute confusion post-surgery.

Nursing staff received and kept up to date with training in the MCA and DoLS training with an overall compliance of 94.6% within surgery. Medical and dental staff received training in MCA and DoLS but did not always keep this up to date. Of the eligible medical staff, 82.9% had completed the MCA level 2 and DoLS training modules, against the trust target of 90%.

We spoke to 3 staff who were able to demonstrate their awareness of MCA and DoLS and gave examples how to identify and address concerns around patient capacity and consent.

Staff made sure patients consented to treatment based on all the information available. For example, we observed consent being sought by a surgeon prior to surgery, explanations of the procedure and risks were given before written consent was obtained.

When patients could not give consent, staff made decisions in their best interest. Staff understood the relevant consent and decision-making requirements of legislation and guidance. For example, a patient had a head injury and was unable to consent for surgery. In this instance we saw the use of consent from 4, a form used for adults who may lack the capacity to consent to investigation or treatment.

We reviewed a total of 15 patient care records for consent forms and all were completed in line with legislation.

Is the service responsive?

Requires Improvement 

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

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the needs of the local population. Senior leaders informed us of the current progress of the new Norfolk and Norwich Orthopaedic Centre (NaNOC) which continued to take shape as part of their ambition to reduce elective waiting list within trauma and orthopaedics. The additional 2 theatres and 21 bedded elective ward would allow the service to sustain the 18 week target. Whilst this was being built, 100 – 120 orthopaedic cases were being provided by independent sectors to support and reduce waiting times.

The trust worked with wider systems to address waits in elective surgery, for example the introduction of digital mutual aid system (DMAS). The service planned to write to patients that were going to wait past 65 weeks for their surgery by the end of October 2023 to give them a choice of where they would like to have their treatment at another centre.

The trust had also introduced a 'think yellow' falls strategy. Patients that were identified as at high risk of falls following the risk assessment were given a yellow wrist band and socks to make it easier for staff to identify them.

Subdivision leaders responded to the demand on the specialities to provide timely care. For example, the chief of service had increased clinics, Sunday clinic for cystectomy patients and same day MRI for urology patients to allow for timely diagnosis and referral.

440 pre operative assessments were carried out at the Arthur South day procedure unit. At the time of inspection, the trust were trialling a tool for urology patients which would rate patients based on a set of questions to highlight those that were ready for surgery to offer surgery at short notice if there were cancellations on the day. This was due to go live mid October 2023.

Facilities and premises were appropriate for the services being delivered. The division had expanded their critical care bed base from 20 to 28 to meet the demand on the service.

The service relieved pressure on other departments when they could treat patients in a day. Staff worked hard to ensure that the first patient on the list was ready for their surgery. However, at times patients would not have their surgery due to theatres running late or no bed becoming available. Patients were discharged up until 10pm.

A daily central flow meeting with senior leaders, matrons and governance leads for the division met every morning to review planned discharges and surgery for the day. They had a shared vision and ensured that flow was maintained to achieve the demand on the day.

The expansion of robotic-assisted surgery had helped to deliver more cutting-edge treatments which had enabled more patients to receive minimally invasive surgery and improve recovery times. This investment led the trust to become one of the first in the country to enable thoracic patients to benefit from robotic-assisted surgery and the gynaecology cancer team were now also using the robots.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The trust had blue wrist bands to identify patients living with dementia. A forget me not flower symbol prompted staff that a patient had dementia care needs. This was supported with the use of 'This is me' booklets in the patients notes. This helped them better understand who the person really was, which could help them deliver care that was tailored to the person's needs. We did not see any patients living with dementia on the ward during inspection to review the use of this.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Meal times were protected for patients on wards.

Access and flow

People could not always access the service when they needed it. They did not always receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Surgery

Managers monitored waiting times. However, patients could not always access services when needed and receive treatment within agreed timeframes and national targets. For example, 309 elective operations were cancelled by the trust for patients in the last 12 months and referral to treatment remained below the national average.

Managers and staff worked to make sure patients did not stay longer than they needed to. The average length of stay from April to September 2023 for surgery was 5.01 days. Staff on EAUS ward used to take out (TTO) prescription packs to assist with timely discharge.

Managers monitored the number of patients whose discharge was delayed and took action to reduce them. Patients with a length of stay (LOS) over 45 days were reviewed by seniors. We reviewed current LOS data for patients over 45 days, 8 out of 20 patients were medically fit and did not have criteria to reside in hospital, of which 5 were awaiting placement. The longest LOS of these 8 patients was 92 days. Patients were therefore not discharged in a timely manner once medically fit impacting on the access and flow from the emergency department and elective patients.

Managers monitored patient moves between wards/services to ensure they were kept to a minimum. The trust reported no non-clinical bed moves in the last 3 months. This was due to the ringfence of surgery bed base. There were escalation areas in use on Denton, Dilham and EAUS whilst on inspection with patients occupying treatment rooms to meet the demand on the service. These were recorded and deemed clinically appropriate by clinical staff through discussions with the surgical bed manager.

Managers and staff started planning each patient's discharge as early as possible. Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Daily red to green (R2G) meetings identified complex discharge planning and need for rehabilitation. Delays in discharge was monitored through the weekly review of R2G reasons. This was fed into the fortnightly R2G meeting and escalated through the senior matrons. EAUS did not run R2G meetings as this process was not suitable as the length of stay was only 48 hours. Flow on EAUS was monitored daily by matrons. Patients that remained on EAUS after 48 hours were reviewed by their accepting speciality team daily with updates given to the nurse in charge to facilitate care and discharge planning.

We reviewed the digital R2G dashboard of the last 3 months for the division that showed that seniors had oversight of daily discharges by pathway and daily referrals by pathway. The highest performance of discharges were the elective wards (Dilham and Denton) with an average of 9.7 and 7.4 discharges per day.

Managers worked to minimise the number of surgical patients on non-surgical wards. During the inspection we found that there were trauma patients on elective surgical wards and 2 surgery speciality outliers on Docking ward due to the demand. We did not see any non surgical patients on the wards we inspected.

Patients were kept in the post anaesthetic care unit (PACU) overnight when suitable ward beds were not available. Data showed 104 surgical patients stayed overnight in PACU in the last 12 months. Patients were kept on PACU to mitigate risk of specialty beds not being available on wards.

The division monitored the number of cancelled elective surgery. We reviewed the last 3 months data from July 2023 to September 2023 and found that a total of 403 operations were cancelled due to clinical, non-clinical and patient-initiated reasons. Of these, 11% of all cancelled elective operations were due to patients not attending. 32% of all cancelled elective surgery was due to non-clinical reasons such as list overran, clinical staff not available, bed availability and emergency admission. Of all non-clinical cancellations 64% were due to the theatre list over running which resulted in patients not having their surgery as planned. Senior leaders told us that they had worked hard to improve theatre utilisation as part of an ongoing focus for the triumvirate and had seen improvements in August.

Surgery

Theatre utilisation was monitored and displayed on a digital dashboard. The trust had a utilisation target of 85% and this was only met by gynaecology and thoracic surgery. The poorest utilisation was within pain management and vascular surgery specialties. The triumvirate had enough theatre capacity to meet the needs of the local community. Provisions were in place for out of hours emergency surgery which were staffed in line with national guidance and the service had flexibility during normal working hours to run double trauma theatres from 8am to 9pm with the opportunity to run a third is required to be more effective.

Cancelled operations treated within 28 days of non-clinical cancellation had declined from 23% between January 2022 to March 2022 to 21.9% between January 2023 to March 2023.

We reviewed the trust's action plan to improve theatre utilisation, which showed 13 of the 14 actions were completed, and improvements were evidenced improved under booking lists, reintroduced confirmed surgery with patients and lateral flow test requirement and governance to ensure priority patients booked in a timely manner.

The trust had created a digital pre-operative assessment system which created a pool of patients that were ready for surgery so that elective lists could be back filled and reduce wastage through last minute cancellations. This was delayed and was due to start in March 2023.

Referral to treatment within 18 weeks remained at 55% compared to the national average of 53.3% between June 2022 and June 2023.

Senior leaders had improved wait times around the elective and cancer recovery. At the time of inspection, there were no patients waiting over 104 weeks. The division were on target to meet the target of no patients waiting over 78 weeks however, recent industrial action had impacted on meeting this target fully. They identified the ongoing risk around orthopaedics, but this would be mitigated once the NaNOC was open and would allow for a sustained 18 week delivery in the future.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

The service clearly displayed information about how to raise a concern in patient areas. A nurse on Easton ward told us she would raise concerns with the ward manager and reported they could also contact the freedom to speak up guardian (FTSUG) at the trust. The link for the FTSUG was on every home screen of all trust computers to allow for easy access.

Managers investigated complaints and identified themes. The ward manger on Denton ward told us there was 1 complaint raised in August 2023 that was currently being reviewed by the patient advice and liaison service (PALS). There were no open complaints on Gissing ward at the time of inspection.

The service monitored the number of complaints for the surgery, critical and emergency care (SCEC) division. Over the last 12 months a total of 432 complaints were received. The trust had a policy to review and respond to complaints within 25 working days. Over the last 12 months the division had met this target for 6 months between October 2023 and April 2023. In May 2023, the response rate was 60%, there had been an increase in the number of complaints received

between February 2023 to April 2023. Themes around complaints were reviewed at speciality and sub board governance meetings and evidenced in meeting minutes we reviewed. In July 2023, the largest number of complaints were regarding appointments, including delays and cancellations followed by waiting times. These were broken down into speciality so that leaders were able to feed this back to teams more locally through team meetings.

Managers shared feedback from complaints with staff and learning was used to improve the service. These were shared with staff and patients through quality boards on wards.

Friends and family test captured feedback on care received on wards. This data was presented within governance reports with both positive and negative feedback scores which were communicated to staff through team meetings and staff emails.

Examples of action taken from feedback received were displayed on boards and on the trust website. These included making the critical care waiting room more child friendly.

Is the service well-led?

Requires Improvement

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

Leadership

Leaders had the skills and abilities to run the service. They worked hard to understand and manage the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The surgical division was led by a newly formed triumvirate in place for 18 months who were also responsible for Critical and Emergency care. The triumvirate consisted of chief of division, director of nursing who had both worked at the trust for over 20 years, and director of operations who had previously worked within the women's and children's division prior to this role. The division had 3 sub board triumvirates formed of chief of service, deputy divisional director and senior matron who reported to the divisional leads to manage the specialities within surgery and the overall divisional strategy.

The newly formed sub board triumvirates allowed for more robust governance at sub speciality level. Priorities and current issues relating to surgery were fed up to the triumvirate through the sub boards. The chief of division was clinical which allowed for a better understanding of the issues the service faced and for staff to raise these issues directly to the senior leadership team.

Staff within theatres and on the wards knew who their senior leaders were and reported they were visible and approachable. For example, 'Talk Tuesday' would have the presence of the senior leadership team on wards alongside the well-being outreach team. They engaged with staff to discuss current concerns and difficulties.

We spoke with 15 members of ward staff who stated they felt valued, supported, and worked with a good team. Ward staff reported feeling supported by their ward managers and matrons. A nurse reported she felt able to raise any concerns and saw evidence that these were escalated in a timely manner.

Surgery

Vision and Strategy

The service had a vision for what it wanted to achieve and a divisional strategy to turn it into action. The trust vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy

The division did not have a specific surgery vision and strategy. Divisional leaders planned services that fed into the overall trust vision. The trust's vision was to deliver 'the best care for every patient' underpinned by the PRIDE values: People focused, Respect, Integrity, Dedication and Excellence. The trust values were clearly displayed around the hospital. The trust had a 5-year strategy which was developed following a 6-month period where they engaged with staff, service users and community partners to ask 'what matters to you?' through workshops, events and a wide range of surveys.

Staff survey results for 2022 had shown little improvement and were below average across all 6 themes. There was a commitment to improving culture, delivering on the people's promise, and improve clinical outcomes. The leadership team had made improvement to the workforce over the last 18 months. Divisionally, the staffing gap was less than 5% during inspection and there was an annualised turnover rate of 9%.

Leaders had successfully delivered on the 104-week target which was the largest in the country and an outpatient transformation programme. The focus from the executive leaders was around 'our patients, 'our staff', this is 'our Norfolk'. During Covid, the trust was a surge centre and staff felt that they showed the East of England region that they could deliver exemplar tertiary centre care. Leaders voiced an ambition over the next 6 months to recreate a sense that 'we can do this' through achieving targets within the division.

The trust worked closely with the other 2 acute NHS hospitals in Norfolk and Waveney to reduce the waiting list for elective and cancer waiting lists through standardised practice, pre-operative assessments, and a single patient target list for all 3 sites for both orthopaedics and urology.

Senior leaders reported the trust worked collaboratively with the integrated care board (ICB) on projects such as waiting well for orthopaedic patients, as well as a focus on falls prevention joint with the local authority for patients awaiting hip and knee surgery.

Culture

Staff did not always feel respected, supported and valued. They were focused on the needs of patients receiving care. The service did not always promote equality and diversity in daily work, and provide opportunities for career development. The service had an open culture where patients and their families could raise concerns without fear.

We spoke with a total of 31 staff and 11 senior leaders, most staff stated they felt well respected and valued. Nursing staff felt support was improving but medical staff we spoke with felt that they were not supported day to day.

A review of the trust's workforce disability and race equality standards demonstrated the experience and impact felt by staff. Priority areas for the trust included harassment, bullying or abuse from staff and discrimination from a manager/ team leader or other colleagues. 31.5% of disabled staff experienced bullying or abuse from other colleagues.

The Health Education England Quality Framework for post graduate medical and dental education, assesses organisations utilising a number of data sources, which include the National Education Training Survey (NETS), the General Medical Council (GMC) National Training Survey (NTS) and the NHS Staff Survey, as well as direct feedback from

engagement visits with both trainees and trainers/educators. Due to negative feedback and a year-on-year decline or inconsistency in responses, NNUH had been placed in enhanced monitoring with the GMC via the Regional Post Graduate Dean, NHS England (NHSE). The trust had a series of requirements (must do's) and recommendations (should do's) across the organisation with some specific to the surgery, critical and emergency care (SCEC) division. These included clinical supervision, education supervision and ability for doctors to attend planned training. An action plan to address these were in place and shared with the GMC on 9 September 2023.

The trust had recruited 200 overseas nurses in the last year; 26 overseas nurses were within the surgery division. This nursing group was reported as being supported through a buddy system on the ward or department. The recruitment and retention lead recognised that support was required for these staff. Feedback from overseas staff was sought and leaders reported that they had listened to this and would act on this. For example, warmer clothes or umbrellas would be more appreciated than existing items within the welcome pack.

A senior matron recognised that there was increased diversity within their workforce due to the workforce plan, this was reflected in the 27 nationalities within theatres alone. The leadership did not represent the diversity of the current workforce at the trust. As part of the trusts recognition and commitment to equality, diversity and inclusion, the implementation of leadership programme for Black, Asian, Minority Ethnic (BAME) staff had resulted in successful promotion within nursing groups at band 6 and 7.

Concerns from patients and family were raised through the patient advise liaison service (PALS), friends and family test and patient feedback surveys. Results were fed back by each speciality and were fed into the overall improvement plan through the existing governance structure. Quality boards present on wards and theatres demonstrated feedback from patients and families regarding care provided.

Staff had regular one-to-one meetings with their managers to raise concerns and a freedom to speak up guardian was in post should they not feel comfortable raising concerns to seniors directly. Duty of candour was embedded and was evidenced in 2 sets of patient's notes that were reviewed during the inspection.

The division's theatre communication boards covered a wide range of information such as allocation, mandatory training, external training, visual boards for patients to identify staff according to their uniform, sustainability board and information board with changes within theatres. The sustainability board gave staff an opportunity to make suggestions on improvements to reduce waste.

Governance

Leaders did not always operate effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had a governance framework in place to provide oversight of quality and safety performance. Local ward and departmental meetings fed into specialty quality governance groups which reported to the divisional board through 3 subdivisional boards. The divisional board reported to the trust board and subcommittee. This was supported by governance meeting minutes we reviewed.

Surgery

We reviewed meeting minutes from speciality minutes, there were no minutes for Ophthalmology due to there being no governance lead for the last 6 months. The service recognised that there were long waits in ophthalmology which carried a potential risk of harm to patients. Surgical speciality held monthly governance meeting throughout this time where ophthalmology was a standing agenda item**.** Minutes provided lacked details around current concerns relating to Ophthalmology.

We reviewed June to July 2023 meeting records, which showed that staff discussed quality and performance to identify emerging risks and review existing risks across the service. Areas covered included staffing, harm free care, serious incidents, complaints, shared learning and other key information. Action plans were not always completed with due dates for accountability.

Following our inspection, we requested WHO checklist audit data. The latest audit showed 18 incomplete WHO checklists across specialities. During inspection we found 3 out of 9 WHO checklists were incomplete. Audits identified the need to improve completion but there was no evidence this had been followed up. There were 2 never events reported between July and August 2023 relating to a lack of WHO safety checklist. Therefore, we were not assured the trust used audits to monitor and drive improvements in quality.

Within theatres, a matron attended the daily operation meeting who then met with service leads and coordinators for the day to highlight concerns raised at the operation meeting that could impact on service delivery that day as well as raise any incidents that occurred over the last 24 hours. Team leaders for gynaecology and urology met with their teams and discussed issues that may affect the smooth running of the list such as bed availability, changes in practice and incidents. A variety of tools such as team meetings, meeting minutes and monthly newsletters were used to cascade key information to all staff.

Senior matrons attended the weekly matron meeting alongside other departments such as finance, HR to ensure that current changes were communicated to staff. The trust operated a matron of the day who would review staffing, flow, and feedback on any incidents to ward staff. Matrons would meet with ward mangers on a monthly basis to review dashboard audits and develop action plans in response to audits which were red, amber, green (RAG) rated to monitor progress and performance.

Senior leaders monitored progress against long waiting lists through a variety of governance processes such as weekly specialty specific elective waiting list harm group meeting, weekly review of waits over 104 days, reason for admission review as well as a fortnightly meeting with NHSE reviewing cancer waits. A report was reviewed by the clinical safety and effectiveness sub board and hospital management board every 2 months. The clinical harm incident group (CHIG) met to discuss individual cases to review if a patient had come to harm which was linked to their wait time. A clinical review would occur with recommendations on change to practice to avoid the reoccurrence to other patients. For example, all children waiting an inguinal hernia surgery were reviewed in terms of impact not just on clinical impact but also how the wait may limit engagement and ability to interact.

A review of the minutes from the CHIG meeting from July 2023 to September 2023 evidenced a robust review of harm that had come to patients whilst on a waiting list. Leaders reviewed the impact of changes made to pathways. For example, in August 2023, the urology pathway had seen a reduction from 150 to 65 patients and histology had seen an improvement with lowered numbers in cancer patients waiting over 14 days for their results.

Incidents were discussed at monthly governance meetings and causes for harm were reviewed. Staff were informed of these through team meetings and discussions to prevent future occurrence were encouraged.

Incidents were discussed with all members of the team involved in a debrief to discuss what happened and how it can be prevented in the future.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They mostly identified and escalated relevant risks and issues and identified actions to reduce their impact.

Surgery sits within the surgical, critical and emergency care triumvirate. This was formed 18 months ago with long standing members of staff from the trust, supported by deputy divisional operations director and deputy divisional nursing director. They reported a robust process to review patient tracking lists (PTL), which was evidenced in meeting records. Oversight of each patient was speciality led with a clear focus on the patient and identified causes in delayed care.

Performance and risk were collated and analysed in a variety of ways to drive improvements. Matrons met on a weekly basis with seniors to feedback on performance and risk on wards. There were plans to start quality improvement boards to drive quality improvement specifically aligned to risks that were identified. However, a review of WHO checklist audits showed that performance was not always improving despite the implementation of newsletters and band 7 meetings to feedback on compliance.

We reviewed the current risk register for the division. All risks were rated and had mitigations in place. These were reviewed at monthly governance meetings and progress was updated on the risk register. The top 2 risks were ambulance offload time and access both scoring 25 out of 25. The third highest risk was clinical risk associated with long waiting lists, scoring 20 out of a possible 25. All senior leaders were able to identify the top 3 risks. Leaders reviewed and identified issues related to the risks. For example, performance progress and review of the top 3 risks were carried out in October 2023 with risk still being rated as high. There was progress with patient waiting times, however leaders were aware of limitations such as limited capacity to meet the demands in orthopaedic impacting on recovery.

Systems did not manage performance effectively, for example during inspection there were identified areas for improvement for records storage, medicines management and servicing of electrical equipment. During this inspection we were not assured that effective action and systems had been implanted to address the concerns. We found poor medicine management across 5 of the 6 wards, overdue servicing dates across wards and records not stored securely on all wards.

Following inspection senior leaders met with the head of pharmacy to produce back to basics training, review pharmacy support on wards. The effectiveness of actions taken have not been reviewed.

Improvement in the documentation of Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms was to be addressed through the divisional governance meeting to feedback to staff. Working groups were being set up to devise an action plan to address the concerns.

Information Management

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

The trust had an audit dashboard where data was uploaded by staff following a completed audit. The tool had set criteria to audit against specific questions which allowed for a comparable review of performance by division, area type, type of audit and by month.

Ward dashboards were discussed monthly with their matron and senior matron, and these were fed into the overall trust dashboard. There was oversight from divisional and trust leadership. We spoke to 5 ward managers, and all had a good understanding of their ward dashboard, performance and reasons for changes in results from the previous month.

Live bed management feed was updated daily at red to green meetings. The trust implemented the 'Red and Green Bed Days' as a visual management system to assist in the identification of wasted time in a patient's journey. Length of stay data was reviewed for patients at a weekly meeting led by the deputy chief nurse specifically looking at stays great than 45 days.

Leaders reviewed data in relation to wait times to identify the blocks with the care at the centre of each review. They were confident they remained on target for the 64-week wait and were ahead of trajectory at the time of inspection. Leaders used data analysis to make specific improvements within specialities, for example same day MRI to facilitate timely diagnostics in urology. Long waits within the lower GI lists resulted in the chief of service increasing clinics to reduce the backlog.

Engagement

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

The 2022 NHS Staff Survey had 4,347 completions for Norfolk and Norwich University Hospitals NHS FT, which was a response rate of 51% for the trust, which was improved from 49% in 2021. This was above the benchmarking group median score (44%). Survey questions were grouped into "People Promise" themes. A score out of 10 was calculated for each theme (higher being more positive) from responses to the questions in that theme.

In addition to the 7 People Promise themes, there were 2 additional themes including Staff Engagement and Morale. NNUH scored below the national acute trust average for all 7 themes of the People Promise and Staff Engagement and Morale themes. Improvements were seen in 5 sub scores, including compassionate leadership and support for work-life balance. There were 12 sub scores that worsened including diversity and equality, inclusion, and work pressure.

Leaders used this feedback to identify key actions under the themes of connecting with teams, recruitment and retention and staff well-being to make changes and improvements. For example, they had divisional representatives on the nursing retention group who were putting in place actions to decrease short notice moves for staff, a 57% improvement had been seen since April 2022. The surgery local equality diversity group (LEDG) had been refreshed and set up for October, with a new Chair within surgery.

The service had a system in place to validate surgical wait lists. Patients were contacted by letter informing them of their wait time and to assess if they still wished to undergo operative treatment, wished to defer if their condition had changed, or sought a private solution. If a response was not received from the patient a follow up phone call was made. Failing this, the GP was notified alerting them no contact had been made. This process ensured waiting lists were validated and allowed operating lists to run effectively.

The use of digital mutual aid system allowed meaningful choice for patients at the point of referral and at subsequent points in the pathway to use alternative providers. This resulted in some orthopaedic surgery being performed at a local NHS trust.

Surgery

The trust also utilised independent health services locally with an agreed contract of 120 treatments a month for elective surgery to reduce the lengthy wait times. Senior leaders were hopeful that the new Norfolk and Norwich Orthopaedic Centre (NaNOC) once built would be self sufficient in managing the 18-week wait as part of the ambition to reduce the elective waiting list.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Achievements within surgery included 7 jointly published research and audit projects nationally and internationally in the past 12 months and 4 ongoing research projects. There were 24 quality improvement projects to improve service and care. For example, a retrospective analysis of pathway of care for patient admitted with an intracranial pathology in order to identify areas of improvement and align this with their partner organisation.

The Recognise & Respond Team had developed and implemented a National Early Warning Score (2) training package available on the trust ESR platform. This enabled staff to access an online training package to ensure that their knowledge and implementation of the NEWS2 cascade was up to date. As a division they monitored compliance of training across teams and had recently undertaken a project on the Life Quality Improvement platform to identify the positive impact on training and the escalation of deteriorating patients. Alongside the monitoring of NEWS2 training they ran a plan, do, say, act (PDSA) cycle implementing the use of an escalation sticker across a selection of pilot wards. The results showed a positive correlation in identifying patient deterioration and appropriate escalation in line with national NEWS2 guidance.

The trust was recognised as a national centre for robotic surgery for many specialisms and was the highest performing utilisers in Europe within thoracic and urology. They had achieved a gold award for lower gastrointestinal services research and their spinal team had been commended by NHSE for their support in supporting patients more locally.

A trust anaesthetist had implemented the ‘golden patient for the day’. The night anaesthetist would identify a patient to be first on the acute list for the day. The team would ensure all checks were carried out to allow for a prompt start to avoid unnecessary delays impacting on the overall utilisation of the daily list. This system was fully embedded during the inspection and had recently won an award by the Association for Perioperative Practice for innovation and improvement in patient care.

Diagnostic imaging

Requires Improvement  

Is the service safe?

Good  

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

Mandatory training

The service provided mandatory training in most key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training. Ninety-four percent of all staff were up to date with mandatory training.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training included moving and handling, resuscitation, health and safety awareness and infection prevention and control.

Staff in computerised tomography (CT), told us they had received specific training which enabled them to review and vet CT scans. Five new staff members within CT were doing this training at the time of our inspection. Staff returning from maternity leave were doing refresher training.

Clinical staff had not completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Since 1 July 2022, all registered health and social care providers have been required to provide training for their staff in learning disability and autism. This should be at a level appropriate to their role. This new legal requirement was introduced by the Health and Care Act 2022. Funding for a course on autism in the workplace had just been approved and training had been booked for October 2023.

Managers monitored mandatory training and alerted staff when they needed to update their training. They held Check and Challenge meetings every month, where mandatory training was assessed through live training records. Email reminders were sent out to staff members to alert them when training was due. Staff told us that they received some protected time to complete their mandatory training.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Ninety-five percent of all staff had completed level 3 safeguarding training for both adults and children.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. They accessed information about safeguarding, contacted safeguarding leads and made safeguarding referrals on the service's intranet.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. If there were concerns of suspected physical abuse, patients would always have a nurse chaperone.

Diagnostic imaging

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinical areas were visibly clean and had suitable furnishings which were clean and well-maintained. The service used an external cleaning and facilities management company. We saw cleaning schedules which detailed who was responsible for each cleaning task.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We saw completed cleaning records within 2 radiology modalities. The cleaning company used the National Cleaning Colour Coding Scheme, which prevents cross-contamination during the cleaning process.

Each radiology modality was expected to carry out an audit of infection, prevention and control (IPC) each week. Between April and September 2023, the nuclear medicine modality completed 100% of all weekly IPC audits, but the radiology department within the emergency department only carried out 60% of these weekly audits. The audits looked at various parameters, such as availability of cleaning wipes, availability of waste bins, cleanliness of mattresses and availability of hand washing sinks. Between April and September, all radiology modalities scored an average of 98% for the IPC audit.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were bare below the elbow, which facilitates effective hand hygiene. Hand washing sinks, which were compliant with health technical memorandum (HTM) 64, and alcohol hand gel was readily available throughout the department. Isolation bays were used for patients who had infectious diseases, such as COVID-19.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed staff cleaning equipment after patient use within plain film, CT, and magnetic resonance imaging (MRI) modalities with disinfectant wipes. We saw that equipment was also cleaned at the end and the start of the day, as part of the daily equipment checks.

Cleaning products and other chemicals were stored in secure locked cupboards, which complied with Control of Substances Hazardous to Health (COSHH) regulations.

Environment and equipment

The design, maintenance and use of facilities and premises kept people safe. Staff managed clinical waste well. Equipment was not always in good working order, which impacted on patient care.

The design of the environment followed national guidance. The service was compliant with Health Building Note (HBN) 6 – facilities for diagnostic imaging and interventional radiology. We saw sub-waiting areas within each modality and same sex recovery areas within the Norfolk Centre for Interventional Radiology (NCIR). Privacy curtains were used to offer appropriate dignity and privacy for patients. This was an improvement since the last inspection. Protective screens offered protection to staff from the risks of radiation where required. Toilets with disabled access were available.

We saw that resuscitation trolleys, emergency equipment and moving and handling aids, such as transfer boards, were readily available within each department.

Diagnostic imaging

The service used the Picture Archiving and Communication System (PACS), which was a secure integrated system which managed and stored all images and radiology-level patient information. This meant that doctors and healthcare professionals throughout the service had easy access to the imaging examinations and staff within the radiology department could view previous images for each patient.

Reporting of diagnostic images was carried out in appropriately lit rooms, on monitors which were back-lit. This created optimal ambient lighting for reporting on diagnostic images. The monitors had daily self-calibration checks. Radiologists and reporting radiographers were not assigned to a specific desk, but 'hot desked' on height adjustable workstations.

Staff carried out safety checks of specialist equipment. Completed daily checklists were visible within each department. The checks included a review of the emergency bells, resuscitation trolleys and the oxygen and suction. The checklist within the CT department was dated, but the checklist in the plain film department was not dated. Staff told us that the checklist in the cath- lab was second checked. We observed an assistant practitioner completing daily checks within the plain film radiology department, which included an assessment of the warning lights, which indicate that the area is a controlled area, and an assessment of the tube and table movements.

Each radiology department completed a daily safety audit. Between April and August 2023, the service scored an average of 97.6% on the daily safety audit. The daily safety audit looked at different parameters such as recording of fridge temperatures and appropriate storage of sharps.

Six resuscitation trolleys throughout the radiology department had signed checklists which demonstrated daily and weekly checks had been completed. The checklist for the resuscitation trolley in NCIR was not with the resus trolley, but in a nearby scrub room. We looked at the equipment within 1 resuscitation trolley, and this matched the signed checklist. One resuscitation trolley had open resus pads on top of it. This was highlighted to staff and they were immediately removed.

All diagnostic x-ray systems were tested through a Quality Assurance (QA) programme. Level A tests were carried out in-house at regular intervals throughout the year, with staff following a rolling rota on the different tests that were required to be completed. Level B tests were performed every 2 years by staff from the East Anglian Regional Radiation Protection Service (EARRPS). EARRPS advised the trust on the safe use of all forms of radiation, completed commissioning testing on all new equipment and were involved in any radiation incidents of concern. The service had appointed a Radiology QA Practitioner, who was the first in the country. The Radiology QA Practitioner was involved in the regular testing of equipment, and trained and assessed the competence of band 5 radiographers to do some of the testing. Email reminders were sent out to all departments to remind them when QA testing was due.

The service had 795 items of personal protective equipment (PPE), in the form of lead aprons, skirts and thyroid shields. Each piece of PPE was logged with a barcode, subjected to acceptance testing when new, and then retested at least every 2 years to ensure it was still effective. The radiology QA Practitioner kept a spreadsheet which showed 99 pieces of PPE were overdue to be tested. As some items of PPE were classed as long-term missing, the service had completed testing on 91% of all items on site (the service aimed for over 90% compliance across the trust).

The service did not always have suitable equipment to image patients in appropriate time frames. While in some modalities, equipment was modern and up to date (such as Nuclear Medicine and the NCIR), equipment failures and downtime had resulted in an impact on service activity, particularly within CT and MRI. There had been 865 appointments cancelled between October 2022 and 30 September 2023 in the year preceding our inspection due to equipment failures:

- 23 days had been impacted due to equipment breakdown within the CT department. Two CT scanners were due to be replaced in 2024. Engineers had told staff that there was no guarantee that 1 of the CT scanners would turn on each morning following the last sustained breakdown in August 2023.
- 48 days had been impacted due to equipment breakdown within the MRI department. However, 3 MRI scanners had recently been replaced and 1 was being refurbished and the impact from equipment failures in MRI was predicted to improve.
- 6 days had been impacted due to equipment breakdown in plain film x-ray department. The service was not using the plain film department on level 2 as these machines were due to be replaced. The main area plain film department operated for longer periods to increase capacity.

There was an ongoing issue within fluoroscopy, where there were delays in the ability to save images. This had been reported as an incident and was put on the risk register on 4 July 2023, as there was only 1 available machine in the trust. This equipment was due for replacement and had been listed as poor condition on the equipment replacement programme.

The trust held a capital equipment replacement programme (CERP). Equipment was risk assessed on the CERP, looking at equipment condition, age of device and if the item was still supported by the manufacturer. The CT equipment listed on the CERP was between 13-14 years old and the plain film x-ray equipment was between 22 and 25 years old, these had a total risk rating of 26 out of a possible 40. This CT equipment was in year 2 of the 5-year plan. Staff told us that replacing aged equipment was often delayed due to contractual processes secondary to being a PFI site. Equipment downtime resulted in cancellation of clinics. This can lead to poorer patient outcomes due to delays in diagnosis.

Staff told us that there was a lack of wheelchairs throughout the hospital.

Staff disposed of clinical waste safely. Clinical waste was segregated according to health technical memorandum (HTM) 07-01. Sharps bins were dated and stored appropriately.

The nuclear medicine department developed a bespoke software system which calculated the dose and waste from each injection. This system was fully supported and approved by Ionising Radiation (Medical Exposure) Regulations, (IR(ME)R). The East Anglian Regional Radiation Protection Service, (EARRPS) provided the service with a radiation waste advisor, who audited the service every 1 to 2 years.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff responded promptly to any sudden deterioration in a patient's health. Patients usually attended the radiology department for short periods of time, with an average wait time of 10 to 15 minutes. Inpatients who were determined to be a high risk of deterioration, would be accompanied by nurses from the ward. Inpatients waited for their appointments within bed bays which were staffed with radiology support workers and nurses. Patient records stayed with patients while in the radiology department. If a patient deteriorated, observations would be taken and recorded against the National Early Warning Scores (NEWS2). NEWS2 is a tool which improves the detection and response to clinical deterioration in adult patients. Staff called 2222 from internal phones in a medical emergency for the crash team, or called the Recognise and Response team on 4444, who were available 24 hours a day, 7 days a week.

Diagnostic imaging

The radiology staff followed the trust's sepsis policy, which outlined the different responsibilities for different staff members, including the portering team. Sepsis 6 bags were available within resuscitation trolleys, and staff followed the sepsis 6 guidelines, knowing to refer patients to the Recognise and Respond Team if there were any concerns about sepsis.

Staff told us what they would do if there was a medical emergency while a patient was having an MRI scan. MRI is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of inside the body. Due to the magnetic field, the resuscitation trolley is not allowed into the room. Staff told us they would immediately stop the MRI scan and staff who worked within the MRI department would evacuate the patient into a holding area, where emergency treatment could be administered to the patient, away from the strong magnetic fields. We saw clear signage on the resuscitation trolley which indicated that it was not safe to be brought into the MRI room. We did not see any evidence that staff had completed recent scenario training on evacuating patients during medical emergencies within the MRI department. This was due to staff shortages.

Simulation exercises for fire drill evacuation within the NCIR had been completed in April 2023. Further scenario training was planned for seizures, choking and deteriorating patients due to bleeds. Scenario training was not planned well in advance, as clinical pressures needed to be taken into consideration.

Staff completed risk assessments for each patient on arrival, using a recognised tool. Staff followed safety pathways and used surgical safety checklists within the cardiac catheterisation lab and the NCIR. The safety pathways followed the principles set out by the World Health Organisation (WHO) and the National Safety Standards for Invasive Procedures Guidance.

All radiology modalities followed policy on the process for gaining consent and identification of patients, by using 3 pieces of identifiable data. In addition, staff cross checked the site that was requested for imaging with the patient to ensure the patient referral was correct.

All patients attending for MRI completed a MRI safety questionnaire to check if patients had implants, pacemakers or aneurysm clips.

Staff knew about and dealt with any specific risk issues. Staff followed trust protocols for administering intravenous contrast media within the CT and MRI departments. Within the MRI department, administration of contrast was only performed by IV trained radiographers, consultant radiologists or radiology registrars. Consultant radiologists or radiology registrars were available on site when contrast was used. Radiographers were not able to administer contrast media to children, patients with poorly controlled asthma or patients who had a history of previous adverse reaction to contrast media, as the risk of anaphylaxis would be higher. The use of contrast media was not used in pregnant women.

Staff were aware of the risk of Nephrogenic Systemic Fibrosis, which is a rare and potentially life-threatening condition associated with gadolinium-based contrast agents. All patients were asked if they had any kidney problems through a safety questionnaire. Glomerular filtration rates (eGFR) were checked on patients with kidney problems, patients who were acutely unwell, diabetic patients and any patient over the age of 65 years old. These protocols followed guidance from The Royal College of Radiologists (RCR) on gadolinium-based contrast. The RCR recommends there should always be an individual in the department who is trained to recognize and treat severe contrast reactions. Staff followed guidance from the National Institute for Health and Care Excellence (NICE) for patients at risk of contrast induced nephrotoxicity (CIN). CIN is acute kidney injury which occurs after the administration of contrast.

Diagnostic imaging

NNUH did not have a specialist allergy service. Patients requiring assessment for allergies were referred by consultants to other services.

Staff locked the MRI doors as part of their initial checks, to ensure no members of the public entered the room during a procedure. Staff asked the CQC inspection team if they had any metal implants or pacemakers before entering the MRI area.

Staff were aware of the risk of extravasation. Extravasation occurs when a medicine designed to be delivered directly into the vein accidentally leaks into the surrounding tissues instead. This can lead to tissue damage, skin irritation, and tissue necrosis.

Lead PPE was available to be used for patient's carers who were required to accompany and support patients within diagnostic x-ray rooms. Appropriate staff wore personal radiation dosimeters and monitoring devices. They measured the amount of ionising radiation each staff member had been exposed to. Staff who worked in areas which would subject them to higher effective doses of ionising radiation, were determined to be classified workers. Classified workers wore 2 types of radiation dosimeters. Staff working in Nuclear Medicine wore ring dosimeters, which measured the doses at the fingers of staff handling radiopharmaceuticals. If any staff member had received doses over the threshold, they were immediately notified. The radiation protection advisor (RPA) for the service was also notified, who would investigate and advise the service on the next measures.

Staffing

The service did not always have enough staff with the right qualifications, skills, training and experience. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service did not have enough staff to keep patients safe. At the time of our inspection, the service had 90 staff vacancies across all radiology modalities. This included:

- 12 vacancies in the plain film x-ray modality,
- 5 vacancies in the MRI modality,
- 10 vacancies in the CT modality
- 6 vacancies in the breast imaging modality
- 24 vacancies for administration and clearical staff
- 11 vacancies for radiology department assistants.

The service had high sickness rates which impacted patient care. Between August and September 2023, 160 appointments had been cancelled across all radiology modalities due to staff shortages:

- Within the CT modality, 6 days had been affected due to staff sickness, resulting in 82 patients being cancelled.
- Within the MRI modality, 7 days had been affected due to staff sickness, resulting in 36 patients being cancelled.
- Within the plain film x-ray modality, 2 days had been affected by staff sickness which resulted in 8 patients being cancelled.
- Within the ultrasound modality, 5 days had been affected by staff sickness which resulted in 23 patients being cancelled.

Diagnostic imaging

The booking team had also experienced staffing challenges. In May 2023, 5 booking staff members were on sick leave. The effects of this impacted booking timelines, with bookings only being up to 10 days ahead rather than the access policy requirement of 3 weeks. At the time of inspection, staffing levels had improved, but the booking team still had challenges when cancelling appointments due to equipment failures and due to industrial action.

There was a backlog of 11,311 diagnostic tests which were waiting for a report. The majority of these images had been taken within the previous 3 months, but there were some outliers, with an ultrasound which had been taken in December 2022. There was a process in place to prioritise diagnostic images for reporting. The service had a business plan approved to add an additional 9 consultant radiologists. They aimed to be at full capacity for consultant radiologists by January 2024. The increase in radiologists would help with the reporting backlog. However, staff told us that there was still a need for more reporting radiographers. The service was looking to outsource some reporting to external teleradiology companies, depending on funding being approved.

Managers used bank and agency staff and requested staff familiar with the service. The service had used bank staff 242 times during August 2023 and 263 times during July 2023. Radiology students were offered the opportunity to join as bank staff and to support the booking team when required. Within breast imaging, 3 agency mammographers were being used to help with delivering both the screening and symptomatic service. The service had difficulty appointing agency staff due to the location of the service and the lack of accommodation.

Managers made sure all staff had a full induction and understood the service. We saw induction packs for different staff roles which assessed staff competencies.

Radiology Assistant Practitioners (APs) were supervised by radiographers within the department and were able to take standard plain film x rays and fluoroscopic examinations once signed off as competent. When no radiographer was directly supervising the procedure, the AP marked in the records 'AP delegated supervision'. Direct supervision was required for x-rays of cervical spines for trauma and when treating children. When examinations where under the supervision of a radiographer, the records were marked 'AP radiographer checked'.

The manager could adjust staffing levels daily according to the needs of patients. Each radiology modality held a daily huddle, where staffing requirements were discussed. Radiology department assistants were moved to different modalities when required to help with daily staff shortages. A revised CT co-ordinator role had recently been implemented to improve planning and co-ordination of inpatient scans. The service was working to implement a co-ordinator role to work with the emergency department to improve patient flow and prioritise patients.

The service had low turnover rates. Staff who we spoke with had been working at the service for long periods of time, and had no intention of leaving.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

When patients transferred to a new team, there were sometimes delays in staff accessing their records. Doctors, nurses, physiotherapists and other non-medical referrers both from within the trust and from GP surgeries made x-ray and scan requests electronically on an Integrated Clinical Environment (ICE) system.

Reports on the diagnostic images were sent back to the referrer via the ICE system once ready.

Diagnostic imaging

Patient notes were comprehensive. Patient notes within the diagnostic imaging departments were electronic. They included a notes section which flagged any risks, such as allergies or diabetes, a record of the dose of radiation the patient was exposed to during the procedure and details of any contrast mediums used for the procedure. Records also included the vetting protocol. Vetting ensures the appropriate investigation has been requested through the review of imaging requests.

Patient records were updated within the control rooms in the CT and MRI department. Staff told us that it would be helpful to have the patient records accessible on a tablet, which could be taken into the imaging room and updated while they were with the patient.

Inpatient records were paper based. These accompanied the patients from the ward to the diagnostic imaging department. Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms were included within the inpatient records. The ReSPECT forms gave a clinical record of agreed recommendations to be followed if there were a medical emergency and that patient no longer had capacity to make or express choices. We viewed 1 inpatient's record and saw that the legal proxy and assessment of capacity sections had not been completed. Staff told us that they often found that these forms were not completed properly.

Staff within the diagnostic imaging department told us they completed mental capacity forms when required. Stickers were placed in patient records to indicate if a patient had dementia and staff understood that capacity could fluctuate. They told us that patients who could not tolerate the diagnostic procedure would have a general anaesthetic only if it was determined to be in their best interest.

Records were stored securely. Images were uploaded onto the Picture Archiving and Communication System (PACS), a digital imaging display and storage system. This enabled images to be viewed anywhere in the hospital, so that doctors and healthcare professionals had easy access to the imaging examinations they requested.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. We saw patient group direction (PGDs) for the administration of 5 different medicines. Patient group directions (PGDs) allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription. The PGDs included details of any contra-indications, dose, route of administration and any potential side effects. The PGDs were signed by the lead clinician for each department and by the practitioner who was acting under the PGD, to confirm they had the training and competencies.

Radiographers administered gadolinium-based contrast media in accordance with local PGDs. Staff competence was assessed through clinical skills training, where competencies in intravenous (IV) cannulation, IV peripheral drug administration and cardiopulmonary resuscitation were assessed. IV contrast media could only be drawn up by an IV trained radiographer, nurse or radiologist and second checked by an appropriately trained member of staff. All IV contrast media was prescribed by a radiologist prior to the administration by a radiographer. Radiology department assistants (RDAs) and assistant practitioners (APs) could be trained and assessed for competency to perform the second checks.

IV pressure injectors were operated by radiographers who had received the training and signed off as competent.

Diagnostic imaging

All staff that perform the justification of the administration of radioactive substances were required to have a licence from the Administration of Radioactive Substances Advisory Committee (ARSAC) under regulation 5 of the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017. A radiation safety assurance report was performed by the radiation safety and quality assurance lead, which provided assurances if licences were up to date. We saw the employer licence for the trust was due for renewal by March 2024. Eleven consultants had up to date licences, with 1 due for renewal by December 2023. Clinicians were alerted by the radiation safety and quality assurance lead if their licence was due to be renewed within the next 6 months. One clinician was no longer entitled to act as an ARSAC practitioner as their licence had expired in April 2023. This clinician did not plan to renew their licence.

Staff reviewed medicines regularly. Sterility testing was completed every week on the radiopharmaceuticals used in nuclear medicine.

The service was developing initiatives to get contrast preparations to patients in a more streamlined manner via patients GPs for CT virtual colonoscopies (CTCs). Following successful trials, the service moved from a 2-day preparation, involving both diet and contrast, to a 1-day preparation. This allowed the service to make better use of short notice cancellations.

Staff stored and managed all medicines and prescribing documents safely. Oxygen cylinders were stored upright in racks. Throughout the MRI, CT and Nuclear medicine departments, we saw daily checks were completed on medicines and controlled drugs, with records of fridge and cupboard temperatures fully completed. Contrast agents were stored in warming fridges, which kept the temperature between 36 degrees Celsius and 46 degrees Celsius. This was an improvement compared to our last inspection.

The Nuclear Medicine department was connected to a temperature monitoring system which was monitored by the pharmacy.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. They followed the service's patient safety incident response policy, which was in line with the Patient Safety Incident Response framework (PSIRF). The PSIRF had replaced the serious incident framework which was a key part of the NHS patient safety strategy. This had been implemented from September 2023.

Between 1 January and 31 August 2023, 333 incidents had been logged in the incident reporting system. Staff told us that staff shortages and equipment breakdowns were a recurrent theme. We saw 4 incidents reported by the Fluroscopy team which related to equipment failures. It was highlighted on the incident report that while this equipment was on the CERP, there was no date scheduled for replacement and that was the only unit in the trust.

Staff raised concerns and reported incidents and near misses in line with the service's policy. They reported incidents on the service's incident reporting software and assigned each incident a level of harm. Each incident was reviewed and triaged by the radiology governance team and assigned to an appropriate management pathway - green, amber or red.

Diagnostic imaging

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. A patient safety review was completed for incidents classed as amber, where learning was identified. More complex incidents, or those which were classed as red, were allocated to a complex case review group. Individual investigators were appointed and the patient and/or their family would be involved in the review of the draft report.

The medical physics team at EARRPS had been informed of an incident which had occurred within the Nuclear Imaging department.

The service had reported no never events. Never Events are serious, largely preventable safety incidents that should not occur if the available preventative measures are implemented.

There were 18 incidents in the year preceding the inspection which were due to images not being reported or images or results lost or delayed. Seven of these incidents related to the images not being correctly uploaded onto the PACs system. We saw that the systems in place to prioritise the reporting of images for more urgent cases had failed in 2 incidents. In January 2023, when a radiographer noted an abnormality, the images were not flagged for hot reporting by either the radiographer or the radiologist. The service had found there had been no harm to the patients as a result of these incidents.

Managers shared learning about incidents with their staff and across the service. We saw learning points and actions taken in response to 5 incidents across each modality within radiology. Incidents were discussed within staff meetings and documented in the meeting minutes. Staff directly involved in any incidents were reminded on correct protocols where necessary. For example, following an incident when in-patient records went missing, staff were reminded to bring all notes into the control room while a patient was in attendance for an imaging procedure. Radiologists met monthly to discuss discrepancies for particular patients, where their reports had been called into question.

Managers shared learning with their staff about incidents that happened elsewhere, and staff received feedback from investigation of incidents, both internal and external to the service. Incidents which occurred on the outsourced mobile units were discussed within staff meetings. For example, a radiographer on the outsourced MRI unit had failed to place cod liver oil markers to distinguish between both knee images. This was discussed within a quarterly service review meeting with the provider of the mobile unit and within internal staff meetings, to ensure learning was shared with the wider team.

Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback. An incident within the NCIR, where a patient had an adverse reaction to a platelet transfusion, triggered further education specifically for transfusions. The clinical educators for the ward and the NCIR were linked to ensure that the learning was shared across both areas. This incident and associated learning was discussed at the NCIR governance meeting.

Duty of candour was followed. The service was open and transparent and gave patients and families a full explanation if and when things went wrong. A record that duty of candour had been carried out was recorded in patient records.

Is the service responsive?

Requires Improvement 

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

Diagnostic imaging

Service delivery to meet the needs of local people

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

Facilities and premises were appropriate for the services being delivered. The Norfolk Centre for Interventional Radiology (NCIR) provided minimally invasive procedures using advanced radiological image guidance. This meant the risks to patients were lower and recovery was faster compared to open surgery. The unit had 4 interventional suites. Two interventional suites had the latest technology C-arms installed, which enabled precision guidance in procedures such as biopsy, embolisation and endovascular aneurysmal repair. The other 2 suites have the latest technology robotic arms. The NCIR had same sex recovery areas.

The Boudicca Breast Care Unit had been developed with money raised from the Norfolk and Norwich Hospitals Charity. The breast imaging department provided mammography and breast ultrasound services, with 3 mammogram units, 3 ultrasound rooms and a counselling room. The service had a 4th ultrasound machine and were planning to refurbish another room to be used for ultrasound. There were separate waiting areas for patients who were symptomatic and those attending for routine screening. The service offered a one stop service, with biopsies carried out on the same day as assessment. The service held nurse led results clinics, with surgeons available so patients could be introduced to the surgeon on the same day.

The service had 5 ultrasound rooms within the radiology department at NNUH, 5 antenatal ultrasound rooms, 1 ultrasound within the vascular lab, 1 ultrasound at the hospital in Cromer, and a portable ultrasound machine which was used for outreach sessions. The service also had a urology one-stop clinic where patients were sent for ultrasounds on the same day.

The service has 3 MRI scanners at NNUH and 1 MRI scanner at Cromer Hospital, and 2 outsourced MRI scanners within mobile units. MRI scans were performed between the hours of 7am and 8pm, 7 days per week. In addition, there were 5 in-house CT scanners within NNUH and 1 outsourced CT scanner with a mobile unit. CT scanners operated 24 hours a day, 7 days per week.

Staff for the mobile units were supplied by the independent provider of the mobile scanners. The booking of patients and reporting of images was managed by the NHS trust. The mobile units operated between 8am and 8pm, 7 days per week.

Bone density scans (DEXA) and fluoroscopic x-ray examinations were performed each weekday between 8am and 4pm.

The service had 5 cardiac cath labs, but only 3 were in operation on day of inspection. The procedures performed in a cath lab use catheters to access the heart and blood vessels and include the placement of pacemakers, angiograms, and percutaneous coronary intervention (PCI). Lab 5 was the newest lab, but lab 2 was due to be replaced. The cath lab manager told us that a business case had been submitted to approve an extra 4 sessions, which would increase capacity to meet demand.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. The service offered same day staging CT scans to patients who had a probable diagnosis of colorectal cancer identified on the CT virtual colonoscopy (CTC). This service had been introduced in January 2023, following intensive training for the reporting radiographers and advanced practitioners to administer the contrast. This was provided for both patients attending for screening appointments and patients who were

symptomatic. This greatly improved waiting times, as those patients were referred immediately to the multidisciplinary teams for treatment. British Society of Gastrointestinal and Abdominal Radiology, (BSGAR) standards expect 80% of patients to have same day staging. By implementing this training, the service had gone from 0% compliance to well above the national standard of 80% compliance, with exact figures to be confirmed with a formal audit.

The service had been closely monitoring the CTC recovery following the changes made to implement same day grading scans. Following the COVID-19 pandemic, the backlog of patients was 286 patients and there was over a 6 week wait for 2-week (2ww) appointments. In September 2022, there were 171 outstanding 2ww requests, and 2ww patients were being booked in between 4 and 5 weeks. In September 2023 this had decreased to 73 outstanding 2ww requests and the time for appointment for 2ww patients was under 2 weeks. Routine appointments were being booked in within 2-3 weeks, compared to 10-12 weeks in September 2022.

Additionally, training had been provided to advanced practitioner radiographers to reposition nasogastric feeding tubes within the department. This saved time, as patients did not need to be sent back to the ward to have the nasogastric tubes repositioned and rechecked.

Managers monitored and took action to minimise missed appointments. The service completed an audit of 100 patients who had failed to attend their appointment for a bone density scan between 1 January and 31 December 2022. The audit found that 42% of those patients had left a message on the answerphone to rearrange the appointment and 24% did not receive the appointment letter. Changes were implemented, which included making time for clerical staff to check messages daily and using a specific bone density scan email address which could be checked daily. The audit coincided with postal strikes, which explained the rise in patients who had failed to attend, as they had not received the letter.

The service had protocols enabled certain qualified health professionals to refer patients for radiological examinations, to provide patients with timely health care management. One protocol enabled named registered upper gastrointestinal clinical nurse specialists to request radiological examinations for upper gastrointestinal cancer patients for staging examinations, surveillance CT scans and post operative imaging for patients presenting with symptoms suggestive of recurrent disease.

Managers planned and organised services so they met the changing needs of the local population. NNUHFT had been awarded funding to build a new diagnostic and assessment centre (DAC), which was due to be completed in 2025. The DAC would increase diagnostic radiology capacity to align with the increased demand. The service had calculated that the DAC would require an additional 16 radiologist consultants. Registrars who we spoke with were keen to stay on at the service. Managers told us they wanted to 'grow their own' staff, supporting existing staff to progress into new roles for the DAC. The service had recently appointed 4 apprenticeship assistant practitioners who would eventually work within the DAC.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

From September 2023, the daily safety audit had changed to a Fundamentals 1 – Quality and Safety Audit and Fundamentals 2 – Observation of Care Audit. These audits were completed weekly and looked at different parameters such as paediatric waiting facilities, evidence of dementia champions, and updated staffing boards.

Diagnostic imaging

We saw water fountains in some of the waiting areas and seating which was suitable for people with additional mobility needs.

The service was in the process of identifying spaces which could be used for private discussions with patients and gaining consent.

We saw a child-friendly waiting area within the ultrasound department and a treatment room within the MRI department, which was used to administer sedation to children. A dedicated paediatric sedation clinic was supported by 2 paediatric radiography department assistants. All children who had an MRI scan were gifted a present after their scan, which had been gifted by members of the public via a link through a quick response (QR) code.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. The daily safety audit looked at different parameters, including if patients with dementia had appropriate records. We saw in June 2023 only 50% of patients with a diagnosis of dementia had a 'This is me' booklet completed, but this had improved by August 2023.

Staff demonstrated a good understanding of the Mental Capacity Act 2005 and the 5 principles in supporting people to make their own decisions. However, a mental capacity audit conducted between October 2022 and September 2023, demonstrated that 98.5% of patients flagged as having dementia did not have a mental capacity assessment completed. The outcomes of the audit had been taken through radiology governance and an action plan had been put in place to improve compliance.

The service was trialling the use of an inclusive pregnancy status form during our inspection. They had recognised the need to capture all patients, regardless of gender, who can become pregnant before commencing with any radiological procedure. All patients between the age of 12 and 55 years of age, who were undergoing an x-ray procedure between the diaphragm and knees, were asked to complete an inclusive pregnancy status form. If there was any doubt regarding pregnancy status, clinical urgency was considered. Patients would be offered pregnancy tests, or if not urgent, the procedure would be delayed until pregnancy status could be confirmed.

The service was promoting a breast screening campaign which was being supported by the LGBTQ+ community.

Patients, loved ones and carers could get help from interpreters or signers when needed. Staff had access to a digital communication software which provided relevant information to patients in 20 different languages and sign language videos. However, the inspection team did not see any information which informed service users that this software was available. During our inspection, we saw an interpreter accompany a patient to have a CT scan.

Access and flow

People were not always able to access the service to receive the right care promptly. Waiting times for diagnostic images and interventional treatment were not always in line with national standards.

Managers monitored waiting times and were implementing measures to improve access to services to meet national targets. Capacity and demand were monitored daily by modality leads.

Diagnostic imaging

Patients were prioritised for treatment within the NCIR depending on their clinical need and risk. Patients categorised as P2 were patients who required treatment within 28 days. Between June and September 2023, 24 patients were breaching P2 status (over 28 days wait). The longest wait for P2 patients was 109 days, however, this was due to the patient delaying the procedure until their family could be available to help them on discharge.

For non-urgent procedures, the NCIR had 342 patients waiting for their procedure. This had increased by 20 since August 2023. Of these patients, 16 had been waiting for over 65 weeks for their appointment. On the day of inspection, 1 patient had been waiting 75 weeks for their procedure. Three patients were booked in for their procedures in October 2023, with the referral to treatment time being 73 weeks for each case.

Due to staff shortages, only 2.5 of the 4 interventional suites were utilised within the NCIR. The NCIR department had submitted a business case for an investment in staffing, which would open more imaging suites from 2.5 labs to 4. The NCIR was aiming to avoid patients waiting for more than 65 weeks by end of March 2024. The service aimed to be on target with P2 patients (treating them within 28 days) by February 2024.

The service recorded all requests to attend and compared them to diagnostics waiting times and activity (DM01) targets within each modality. This included:

- Target for referrals to CT and ultrasound from A&E for suspected stroke was 1 hour - target was met 83.4% of the time.
- Target for urgent referrals to CT, ultrasound, MRI, nuclear medicine and x-ray from A&E was 1 hour – target was met 75.4% of the time.
- Target for referrals to x-ray department from GP direct access referrals was 28 days for routine and 3 days for urgent referrals – target was met 100% of the time.
- Target for referrals to CT and ultrasound for inpatients suspected of stroke was 1 hour – target was met 26% of the time.
- Target for referrals to CT, fluoroscopy, ultrasound, MRI, nuclear medicine and x-ray department for outpatient 2-week wait was 7 days – target was met 26.9% of the time.

Overall, for all referrals across all radiology departments, the request to attend target was met 68.7% of the time. DM01 data is collected by NHS England monthly, which details waiting times and activity for 15 key diagnostic tests and procedures.

Within Nuclear Medicine, 1 patient had been waiting for 8 months for a non-urgent renogram. We saw a patient had been referred to nuclear medicine on 1 September 2023 for possible metastatic cancer. The target was to scan by 11 September, but the patient had the scan carried out on 28 September (17 days over the target time).

The service had recognised there was a need for more booking staff, to ensure available capacity was filled and make the service more streamlined. The service had received funding for an additional 6 booking staff through the Diagnostic Strategic Investment in March 2023. Four booking staff had started in July 2023, and an additional 2 were due to start in October 2023. In addition, existing booking staff and other radiology staff were cross trained, to enable them to book in more than 1 modality.

Staff shortages, equipment downtime and recent industrial action had impacted waiting times and the ability to meet DM01 targets. Staff shortages were a national problem, with the Royal College of Radiologists clinical radiology UK

workforce census 2020 report predicting a shortage of 3600 radiologists (equivalent to a 44% shortfall) in 2025 and The Richards Review, Diagnostics: recovery and renewal (2020), advising that an extra 4,000 diagnostic radiographers, 2,000 radiologists and 220 physicists, in addition to several other imaging workforce groups, were needed to keep up with demand.

Managers were implementing many measures to address these issues. Four international radiographers had been recruited and were in the process of training through a preceptorship programme within the x-ray department. The MRI, plain film and Nuclear medicine departments have appointed 2 apprentice assistant practitioner posts per modality.

Overtime had been offered to existing staff and bank work was offered to student radiographers. Additional booking staff had been sourced and the service had introduced a working group between the emergency department and radiology, and a co-ordinator to prioritise patients from the emergency department. In addition, the service used outsourced mobile MRI scanners and CT scanners to increase capacity and had appointed a CT co-ordinator to improve planning and co-ordination of inpatient scanners. Inpatient scanning was extended between 5pm and 7pm Monday to Thursday to open up additional capacity, and MRI scanners had been upgraded, which meant the scans could be 5-10 minutes shorter. The service aimed to implement training, so ward staff could complete the cannulation process, which would free up time within the CT department.

Staffing levels had an impact on both waiting times and on the reporting of diagnostic images. Turnaround time (TAT) in imaging is the interval between an imaging examination and a verified report being made available to the referring clinician. Keeping TATs as short as possible is essential for timely diagnosis and treatment of patients. At the time of inspection, the service had a backlog of 11,311 unreported images. The majority of these were from 17 June 2023 (3 months backlog), but there were some outliers, with an ultrasound from December 2022. There was a risk that disease could be missed by the operator (person carrying out the imaging procedure) until a radiologist or reporting radiographer reported on the images. All images were reported on in-house. Reporting of diagnostic images was carried out by consultant radiologists, radiography registrars and reporting radiographers were able to report on plain film x-rays. Diagnostic images were hot flagged if there were concerns seen by the radiographer involved in taking the image. The service had appointed a Reporting Workflow Co-ordinator, who managed outstanding reports, and identified and escalated more urgent cases. We saw there had been at least 2 incidents were there had been a delay in patient's receiving their diagnoses due to the images not being hot flagged appropriately for the Reporting Workflow Co-ordinator to action.

The service had a business plan approved to add an additional 9 consultant radiologists. They aimed to be at full capacity for consultant radiologists by January 2024. Trainee registrars who we spoke with were keen to stay with the service once qualified. The increase in radiologists would help with the reporting backlog. However, staff told us that there was still a need for more reporting radiographers. The service was looking to outsource some reporting to external teleradiology companies, depending on funding being approved.

Cancer services and the prostrate pathway clinical and operational teams held a rapid improvement event in January 2023, to identify areas within the 28-day diagnostic pathway that could be improved. Dedicated vetting and reporting times, and additional ring-fenced MRI capacity was introduced. This resulted in an additional 20 slots per week for prostrate MRI scans and reporting turnaround times reducing from 11.5 days in December 2022 to 3.4 days in April 2023.

Posters within the breast screening department advised patients that they could request to be on patient initiated follow up. On this pathway, patients could request follow-up appointments within a set timeframe. This helped to reduce unnecessary appointments and reduced stress for patients.

Diagnostic imaging

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received.

Patients, relatives and carers knew how to complain or raise concerns. We saw posters throughout radiology departments which directed patients to the friends and family test (FTT). FTT asks people if they would recommend the services and offers a range of free text responses. During August 2023, the FTT demonstrated 100% patient satisfaction across radiology.

The service clearly displayed information about how to raise a concern in patient areas. They were directed to report any concerns to the Patient Advice and Liaison Service (PALS). Between January and August 2023, the radiology service had received 29 complaints. Complaints were around waiting times, delays to receiving reports, and parking.

Staff could give examples of how they used patient feedback to improve daily practice. Patients had indicated that signage to the radiology department could be clearer. Signage was reviewed by the patient advocate service and the service was working towards making clearer and better positioned signs.

Is the service well-led?

Requires Improvement 

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

Leadership

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

The radiology department sat under the division for Clinical Support Services. The Chief of Service oversaw both radiology and nuclear medicine. The imaging department was overseen by a Service Operational Manager, Governance Manager and 2 Radiology Operations Managers, with 1 Radiology Operations Manager on secondment at the time of our inspection. Each modality, such as CT, MRI, and the NCIR, had a clinical lead and an operations lead. The Imaging service Manager was the operations lead for nuclear medicine and plain film and theatres.

The radiology nurses were overseen by 2 sisters and a matron. Staff told us that leaders were visible and approachable within each department.

There had been a change in the management structure to drive leadership and implement change within the service. Change was required to develop the overarching radiology plan and to address the issues the service was facing, including staffing levels and reporting capacity. The chief of imaging was an overall leadership role with managerial responsibilities. They were supported by 2 deputies, who would assume some managerial roles and would be project leaders. Subspeciality leads managed their own subspecialities, rotas and business plans. Two subspeciality leads were required for the general radiology department as it was too large and complex for 1 person.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action.

Diagnostic imaging

The radiology department shared the trust values, P.R.I.D.E – they aimed to be people focused, and treat people with respect, integrity, dedication and excellence. These values underpinned the standards of the service delivery and patient care. The trust vision was 'to provide every patient with the care we want for those we love the most'.

Culture

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

Staff wellbeing was a priority at the service. Staff could access wellbeing and freedom to speak up drop-in clinics, wellbeing sessions, menopause support groups and fitness classes, such as Pilates and dance classes. Staff could access mental health first aiders, who were the first point of contact if staff were concerned about their own, or another staff members, mental health.

The service was looking for staff to join a network of freedom to speak up champions, who were the first point of contact for individuals who required advice. They were particularly looking people to represent staff groups who may not feel represented or heard.

The service's raising concerns (whistleblowing) policy stated, 'NNUH seeks to encourage a culture of speaking up in accordance with our PRIDE values (People focussed, Respect, Integrity, Dedication and Excellence) so everyone feels comfortable raising a concern and confident that it will be handled and responded to appropriately'.

We saw some evidence of a positive culture. However, we found low staff morale in the Nuclear Medicine department. Many of the staff who we spoke with wanted to stay on at the service and did not have plans to leave. The service's staff survey for 2022 found that 68.1% of staff felt the service was compassionate and inclusive but only 46.9% of staff felt they were recognised and awarded. Most staff who we spoke with were happy and proud to work at the service, despite the pressures of staffing levels. Managers told us that they aimed to help staff feel empowered to make change.

Staff received regular appraisals where successes, innovations, learning and development opportunities were discussed. Radiology department assistants were given opportunities to move into assistant practitioner apprenticeships and radiographers were supported to develop into reporting radiographers and practice educator roles.

Staff were encouraged to put forward ideas for changes which would drive improvement. Advanced practice radiographers had prepared a presentation which detailed how batch scheduling of in-patient x-ray appointments could improve the efficiency of the service. There was an established patient advocate group, who were working on improving the signage to the radiology department. Staff were able to raise concerns within staff forum meetings. We saw meeting minutes for a band 5 staff forum meeting, where allocation of night shifts were discussed.

Individual staff members and teams were celebrated for their achievements through the service's PRIDE awards. The breast imaging and screening department had won the NNUH silver award for the clinical team of the year in 2022, and the imaging research team had won the research award. The fluoroscopy team who were delivering the same day grading scans within CT virtual colonoscopy had been nominated for the 2023 team of the year.

Diagnostic imaging

The Clinical Support Division had a dedicated equality, diversity and inclusivity (EDI) group who met monthly. Meeting minutes from the last equality, diversion and belonging meeting showed that each division was putting forward nominations for ambassadors who would be involved in tackling health inequalities within people from the most deprived part of the population and ethnic minorities, learning disabilities and autism. EDI was discussed within each imaging operational meeting.

During our inspection, the service was trialling the use of an inclusive pregnancy status form. We saw a presentation which stated, 'The NNUH is committed to leading and promoting diversity, equal opportunities and supporting human rights. As part of this commitment, trans staff and patients should be treated with the same dignity and respect shown to others.' The IPS form was developed to provide guidance to staff. During the 2-week trial, the IPS form was given to all patients, regardless of gender, between the ages of 12 and 55 and who required an x-ray between the diaphragm and knees. Following the trial, the service sought feedback from staff and patients.

The service was promoting a breast screening campaign which was being supported by the LGBTQ+ community.

Governance

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

Capacity and demand were monitored daily by modality leads. Waiting lists were shared and scrutinised by the divisional medical teams. Capacity and demand figures were stored on an online data visualisation platform, which was shared and discussed by the executive management team in divisional performance reviews.

Delays on reporting of images was monitored and logged on the online data visualisation platform. All reporting turnaround times (TATs) were set against targets according to cancer faster diagnosis standards. Between January 2023 and September 2023, there were a total of 63,621 non chest plain film images that required a report. Eight reporting radiographers completed 30,925 reports within this timeframe. Reporting radiographers were allocated annual numbers of reports they should complete, which depended on their clinical commitments. The service conducted a six-month review of activity in July 2023 and found that reporting radiographers were on track to deliver their target. Radiologists and radiography registrars also reported on these images, and while there had been a drive to increase consultant radiologists by a further 9, staff told us that more reporting radiographers were also required.

All appointment TATs were monitored and logged on the online data visualisation platform and set against targets according to cancer faster diagnosis standards and DM01 standards. The data was RAG rated, to help managers identify more challenging areas. Challenges with meeting appointment times had been escalated. Additional booking staff had been funded as part of the Diagnostic Strategic Investment in March 2023, which meant booking of appointments were more efficient and available capacity was filled.

Staff meetings and modality check and challenge meetings were held monthly. Check and challenge meetings discussed workforce, performance, quality and finance.

These meetings fed into monthly radiology operations meetings, modality governance meetings and the radiology governance committee meetings, which were held monthly. Matters arising from these meetings were escalated to the radiology board meeting, which was also held monthly, and the radiation protection committee, which was held quarterly. The divisional operation board, divisional governance committee and the divisional board met monthly. The divisional board escalated issues to the hospital management board, which met weekly.

Performance, in terms of image acquisition and reporting performance, was presented within these meetings. Actual performance was compared to planned performance, with causes for deviation and risks discussed.

The radiation protection supervisors group met bi-annually before each radiation protection committee meeting. Radiation protection committee meetings were attended by the radiology quality assurance lead, operation leads from each modality and representatives from the East Anglian Regional Radiation Protection Service (EARRPS), including the radiation protection advisor and medical physics expert. The meeting held in April 2023 reviewed the radiation protection advisers' report. We saw that the EARRPS team had been performance testing equipment and working on developing a thrombectomy suite and associated shielding recommendations. In addition, the team were assessing the radiation doses to female orthopaedic surgeons, as recent literature had raised concerns of an increased incidence of breast cancer in female orthopaedic surgeons.

The radiation safety assurance report was produced by EARRPS and provided a continued oversight of radiation safety performance within the trust. This report was shared with the clinical safety and effectiveness sub board and the health and safety committee.

The radiology department had robust quality assurance (QA) programmes for each modality. QA procedures and instructions documents outlined each test that should be undertaken for each piece of equipment, to ensure that images were of optimal quality and doses were kept to a minimum.

The imaging clinical governance group met monthly and was attended by the clinical governance lead, imaging service manager, radiology operations managers, imaging matron, radiation protection lead and the quality standards for imaging (QSI) lead. The clinical imaging governance group reviewed processes within radiology and ensured issues were escalated to the divisional board.

Staff forum and staff engagement meetings were held monthly. Topics such as car parking, uniform and cleaning issues were discussed within a staff meeting in September, with staff putting forward suggestions to drive improvement.

Governance documents were stored on a quality management software programme for nuclear medicine. This meant the documents were updated and accessible. For other departments, updating documents was a lengthy process and staff wanted this system to be rolled out across all departments.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The service held a risk register which was specific to radiology. There were 59 items on the risk register; 21 of the risks related to equipment failures and 19 related to staffing issues.

The risk register gave each risk a rating and outlined potential consequences. Control measures, status updates and anticipated closure dates were included.

One of the risks on the risk register was related to older CT scanners. The service had identified that the older scanners gave a significantly higher ionising radiation dose compared to newer scanners. The service had put in control measures so that all children and young adults had CT scans completed on the newer scanners, and the service had timeframes for installation of new scanners.

Diagnostic imaging

Staffing levels across radiology had been added to the risk register in November 2019, and had a risk rating of 16, which indicated a significant risk. The control measures listed included, but was not limited to, home reporting stations for consultant radiologists and reporting radiographers, training radiographers to report on certain x-rays, to encourage flexible uptake of overtime, and to implement a reporting workflow co-ordinator. Some of these measures had been embedded at the time of our inspection. At the end of 2021, the trust had outsourced some of the reporting to an external teleradiology service, but there had been issues with the trust IT system and this was not effective. Outsourcing was considered again in June 2023, but there was a lack of funding. We saw that the risk was reviewed and revisited at regular intervals since 2019 and incidents relating to the risk were linked to the risk register. This risk was discussed at a high-risk meeting.

Each modality had produced a workforce trajectory, listing current vacancies and when they expected those staff to be working independently following a training period. The workforce trajectory for CT estimated staffing would be fully established by February 2024.

Incidents were triaged daily by the divisional governance team to ensure all incidents were allocated appropriately and the severity of harm was correct. The divisional governance team met monthly with each modality to support implementing measures to help reduce incidents. Learning and sharing from incidents was shared with imaging staff and the wider team when required. Incidents were logged against risks on the risk register and themes of incidents were scrutinised to assess for appropriate actions had been taken.

Local rules were available in each department. Local rules identify key working instructions to ensure that exposure to staff or others to radiation is restricted. The local rules detailed contingency plans, which detailed what measures should be taken in the event of an incident involving radiation or radionuclide therapy. Contingency plans were practiced annually, with confirmation of completion sent to the radiation protection lead.

The service reported any device or medicine related incidents to the Medicine and Healthcare Products Regulatory Agency (MHRA). Any incidents involving loss of radioactive material or waste would be reported to the environmental agency.

Diagnostic Reference Levels (DRLs) are dose levels for typical examinations on standard sized patients for broadly defined types of equipment. The DRL list was reviewed annually by the Radiation Protection Committee and guided by recommendations from the MPE.

The service had a standard operating procedure which detailed the processes to be followed in the event of system downtime, to maintain clinical and operational requirements during the downtime period.

Information Management

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

Capacity and demand figures, appointment and reporting turnaround times were stored on an online data visualisation platform, which was shared and discussed by the executive management team in divisional performance reviews.

Diagnostic imaging

The service had a comprehensive audit programme for each modality, with each audit having clear objectives. A record of audits, review dates, compliance and any actions taken were stored within a spreadsheet. An audit completed in June 2023 looked at the average time it took for a patient's x-ray to be completed from the emergency department. Audits to monitor the effectiveness of clinical governance were also included in the audit programme, such as patient feedback audits and an information governance audit.

The radiation support team completed a range of audits including audits on local rules, PPE monitoring audit and CQC incident action compliance audit. An audit was completed in March 2023 to check if all actions and recommendations within the Radiation Physics Expert report had been action on and completed where practicable. The audit found that 30.4% of surveys remained open and required action. An improvement plan was drawn up and distributed to all modality leads to action.

The service conducted monthly audits on patient records. The audit looked as parameters such as if the checklist had been fully completed and uploaded onto the patient records and if written consent was obtained. For the audit in June 2023, the audit looked at 38 patient records from ultrasound. All records had the checklist uploaded, but only 76% were fully completed and 97% included written consent.

The NCIR completed monthly audits to check if the World Health Organisation (WHO) checklists had been completed appropriately. Between September 2022 and September 2023, the audit showed there was 100% compliance.

Radiology Assistant Practioners (APs) were supervised by radiographers within the department and were able to take standard plain film x rays and fluoroscopic examinations once signed off as competent. When no radiographer was directly supervising the procedure, the AP marked in the records 'AP delegated supervision'. Direct supervision was required for x-rays of cervical spines for trauma and when treating children. When examinations where under the supervision of a radiographer, the records were marked 'AP radiographer checked'. Audits of AP images were carried out bi-annually, with 20 images selected for audit per AP. An audit conducted in January 2023 saw that there were positioning errors in 2 out of the 40 images. This was discussed with the individual AP and a reporting radiographer explained the importance of positioning errors.

Regulation 8 of Ionising Radiation (Medical Exposure) Regulations, (IR(ME)R), details the employer's duties for making statutory notifications about accidental or unintended exposures. When accidental and unintended exposures are judged to be 'significant' (or SAUE), or clinically significant (CSAUE), services are required to notify CQC within a specific timeframe. CQC had received the last IR(ME)R notification from the trust in November 2022. For the 2 years preceding the inspection, the trust rarely notified CQC within the correct timeframe (up to 2 weeks from discovery of the incident, and then 12 weeks to submit a full investigation report). The service's ionising radiation policy stated that all heads of department were responsible for ensuring all incidents involving radiation were fully investigated, and the medical physics expert or radiation protection advisor should be consulted for advice.

Engagement

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

The service had service level agreements in place with a third-party company to supply an additional 2 CT scanners and 1 MRI scanner on mobile units. Staff for the mobile units were supplied by the independent provider. The booking of patients and reporting of images was managed by the NHS trust. The MRI scanner scanned 22 patients per day, with the aim of delivering 6310 scans per year. Each CT scanner aimed to scan 34 patients per day, with the aim to scan 10,690

patients per year. Quarterly review meetings were held with the independent provider where performance, complaints, incidents, planned and unplanned downtime, and self-audit results were discussed. The independent provider logged all incidents and shared them with the service. The independent provider carried out its own investigation, identified any learning and shared this with the trust. We saw that the mobile MRI scanner had 29 hours of downtime during March 2023 due to an error with the cooling system, and 17 patients were cancelled due to staff sickness. Trust policies and standard operating procedures were shared with the staff working on the mobile units. Meeting minutes from a service review meeting highlighted that staff on the mobile units had worked pro-actively, calling trust radiographers whenever vacant slots came up and working with the booking team to fully utilize the service.

The service had excellent working relationships with the East Anglian Regional Radiation Protection Service (EARRPS). EARRPS advised the trust on the safe use of all forms of radiation. Staff from the EARRPS team told us that NNUH radiology service was compliant in the region.

Norfolk and Waveney ICS had received funding to build 3 new diagnostic assessment centres, which the trust were to host one of these. These were due to complete in February 2025. The new DAC would provide increased capacity to support in the rapid diagnosis of disease, with a view to reduce waiting lists, including cancer diagnosis.

Multi-disciplinary team (MDT) meetings were held weekly, to keep teams connected. There were MDT meetings with colorectal, stroke and head and neck teams. A cardiology meeting was held with the London heart Hospital each week.

Managers told us that they collaborated regularly with other NHS trusts.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The imaging teams aimed to develop services through continuous learning, quality improvement programmes and research. There was a strong emphasis on providing staff with opportunities to grow and progress. The radiology nursing team had all been trained in conscious sedation, which made it safer for patients receiving conscious sedation. The service had a radiographer who had qualified as a magnetic resonance safety officer, (there were only 100 of these roles across Europe). We learnt about the introduction of a quality assurance (QA) practitioner, which is the first in the country. The QA practitioner had been involved with developing a software to monitor the QA programme across all diagnostic modalities.

Learning was encouraged and shared between teams. Radiologists met monthly to discuss discrepancies for particular patients, where their reports had been called into question. These meetings provided a forum for a collective review of each case study and to provide feedback and learning outcomes. A challenging case regarding a fishbone was shared with the wider team within a presentation. We saw a quality improvement project on redefining the duty radiologist's role to improve scan waiting times for inpatient and emergency department CT scans.

The service worked closely with the University of East Anglia and we learnt that the radiology matron had developed a training module for radiology specific interventional training, which was the first of its kind in the country. The service was looking forward to welcoming the first direct entry MSc Diagnostic Radiography students, existing assistant staff were encouraged to apply.

Diagnostic imaging

The East of England Radiology Academy opened in November 2005. The academy provided training in dedicated facilities, aiming to increase the number of consultant radiologists to meet demand. Registrars told us that subspeciality training was excellent at NNUH.

The service was working towards Modernisation of Workplace Environment in Radiology (MOWER) standards, with rise and fall desks in all consultant and registrar rooms and appropriate chairs. The on-call recliner chair had been upgraded and the secretarial team had been provided with laptops to allow for flexible working. All staff with musculoskeletal issues had their workspaces assessed.

The service trialled artificial intelligence (AI) based software to improve the detection of lung nodules and to support the interpretation of brain scans, which helped inform decisions for stroke patients. This technology reduced the time between presenting with a stroke and receiving treatment, which in turn improved recovery rates. The service was looking to implement AI technology within the breast imaging. Governance of the use of AI was overseen by 2 AI leads.

The service was working towards compliance with the National Imaging Strategy. This was an imaging network, developed according to guidance in consultation with The Royal College of Radiologists, Society of Radiographers and Institute of Physics and Engineering in Medicine.

The radiology department had been awarded and maintained the Quality Standards in Imaging (QSI) Award since November 2012. Accreditation is the formal recognition that an imaging services provider has demonstrated that it has the organisational competence to deliver against key performance measures. These measures require the department to achieve high standards of service in relation to patient care and choice, safety, fit-for-purpose facilities, and clinical practices. Action plans had been implemented to ensure compliance with the QSI award and on recommendation from the last QSI inspection in August 2023.

The radiology department actively participated in research studies. An imaging research team had been working on a neuro-imaging trial within MRI, and were the fastest site in the country to recruit to the trial. The imaging research lead had won the National Institute for Health and Care Research inspiration award and another staff member had received a research scholarship programme. The radiology department had a portfolio 76 research projects, with each research project having an allocated radiologist. NNUH was the first hospital in the UK to carry out a cutting-edge imaging technique that creates 4D flow images of the heart.

The radiology green group developed initiatives to make radiology more sustainable, such as turning off equipment when not in use, reducing the use of unnecessary single use items and finding sustainable procurement of materials, such as reusable sharps bins.