Norfolk and Norwich University Hospitals NHS Foundation Trust

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

The Care Quality Commission (CQC) undertook an unannounced responsive inspection between 4th and 6th March 2015. The inspection rationale related to an increase throughout 2014 of negative intelligence regarding various areas within the Trust. Therefore the inspection focused specifically on accident and emergency services, capacity and demand, medical care and cancer services, surgery, and overall leadership of the trust.

The Trust operates across two primary sites, one in Norwich, the second in Cromer. The Norfolk and Norwich University Hospital was rebuilt in 2001 and is based on the Norwich Research Park. Cromer and District Hospital was rebuilt by the Trust in 2013.

The Trust provides a full range of acute clinical services plus further specialist services and a small private practice. The Trust has 1,099 acute beds and It provides care for a tertiary catchment area of approximately 1,024,000 people from Norfolk and neighbouring counties. The hospital also has an important role in the teaching and training of a wide range of health professionals, especially in partnership with the University of East Anglia.

Previous inspection by the CQC took place on the 2nd and 3rd December 2013 and had resulted in one compliance action in respect of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services. During the responsive inspection we also followed up on the current status with regard to this compliance action. The trust had completed and implemented an action plan and significant improvements had been made. We judged that the Trust was now meeting this requirement and therefore have removed this compliance action.

There were serious concerns raised regarding board effectiveness and a bullying culture within the leadership team. The Trust since Q2, 2014 has been breaching on national targets, ED waiting times, Cancer services and referral to treatment time. This has increased pressure on the leadership and staff teams to meet targets and raised concerns that patient care may be affected.

Our key findings were as follows:

- The trust had taken action in respect of capacity management in the emergency department on a day to day basis however a cohesive strategic plan for access and flow of patients was lacking.
- Capacity and target pressures have led to the Board being too operationally focussed and reactive and there was an inconsistent management approach to staff at a local level.
- There was evidence of a dysfunctional executive team where the current dynamics and tensions were affecting individual's ability to apply due diligence and proper governance.
- The trust had implemented a new governance framework in December 2013 and we found that there was no process in place, and a lack of challenge and scrutiny by the board, to provide assurance to the board that this framework was effective.
- There was no clear process in place, at board level, to manage allegations made by whistle blowers and other third parties.
- The trust had not considered the arrangements it needed to put in place in order to demonstrate that it met the requirements of the fit and proper person regulation and there was a lack of decision making present regarding the appointment of new directors.

The trust needs to make the following improvements:

- The trust should review its governance arrangements to ensure that sufficient assurance is given to the board on the effectiveness of such arrangements.
- The trust should ensure that they develop measureable plans to regain a unified direction and minimise impact of the divisions within the leadership team upon the staffing body and ultimately patient care.
- The trust should ensure that appropriate and swift action is taken to address the bullying culture which is alleged to be present within the trust and ensure effective monitoring and follow up takes place.
- Ensure that it has effective arrangements in place to ensure that all directors, or those performing the functions of a director, are fit and proper in line with regulation 5 of the Health and Social Care Act Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Summary of findings

- The trust should ensure that there is a clear strategic escalation plan in place for access and flow of patients through the emergency department and that there is a consistent management approach in response to high demand pressures.

The inspection included review of the accident and emergency services, medical care, cancer and surgery services and this is reported in the location report. At a provider level, i.e. trust senior level, we reviewed the key question is the service well led as we had received a number of concerns in this respect. We will be carrying out a comprehensive inspection in 2015 where we will follow up the findings and consider any improvements made.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Norfolk and Norwich University Hospitals NHS Foundation Trust

- The Norfolk and Norwich University Hospital is an established 1099 bedded NHS Foundation Trust which provides acute hospital care for a tertiary catchment area of up to 822,500 people. Acute hospital care means specialist care for patients who need treatment for serious conditions that cannot be dealt with by health service staff working in the community.
- The Trust provides a full range of acute clinical services, including more specialist services such as oncology and radiotherapy, neonatology, orthopaedics, plastic surgery, ophthalmology, rheumatology, paediatric medicine and surgery.

The Care Quality Commission (CQC) undertook an unannounced focused inspection between 4th and 6th March 2015. Prior to this inspection the CQC had received a number of whistleblowing concerns, patient complaints and contact from the local health economy regarding the functioning of this trust. This inspection was therefore undertaken to follow up on those concerns which had been raised and focused specifically on accident and emergency services, medical care and surgery, and overall leadership of the trust.

Our inspection team

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

How we carried out this inspection

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

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

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

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

What people who use the trust's services say

- Throughout our inspection, we witnessed patients being treated with compassion, dignity and respect. We saw that call bells were answered promptly on most wards. Patients confirmed that staff were caring, kind and compassionate. Our observations demonstrated that staff acted to protect people's dignity before it became compromised.
- Screens were pulled to ensure patients privacy when any care was being carried out.
- Staff spoke to people with care and compassion and they supported patient choice. For example, on Elsing Ward patients were encouraged to mobilise and sit where they chose.
- All patients were appropriately covered and clothed so as to protect their dignity.

Summary of findings

- People commented that nursing and care staff were "kind" and “helpful”. One person told us, that they felt the service provided to them was “first class” and another person stated they could not fault any aspect of the care provided to them.
- Patients were helped with meals and drinks in an unhurried way. Staff actively engaged with them and maintained conversation with obvious rapport.
- Patients were asked by staff what they liked to be called during their stay on the ward and then used that title when talking to them.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust well-led? There was a disconnect within the leadership team at the trust. We found that there were inconsistent views on the priorities for and the risks facing the trust. At the time of our inspection, the leadership team were acting reactively to address the problems it was facing and there was a lack of focus on long term sustainability. Our inspection highlighted concerns with regards to the culture within the trust which emanated from the most senior management. We spoke with 13 people who either reported they had been directly bullied, had witnessed this happening or who had been made aware of such behaviour taking place. The trusts 2014 staff survey also demonstrated that a bullying culture was in existence with 29% of staff reporting that they had been bullied or harassed in the past year. This placed the trust in the worse 20% of trusts for this indicator nationally. Whilst we found that some concerns had been raised with members of the board we were not confident these were being sufficiently addressed. Plans to address wider cultural issues were in their infancy and at the time of inspection assurance could not be provided in relation to the actions and timescales in which improvement should be seen. In November 2014 a new legal requirement came into force which imposes on trusts to have in place fit and proper people at director level. We found that although a director appointment had been made following the implementation of this regulation, the trust had not considered how it could demonstrate it was meeting this requirement. We found no formal processes in place and appropriate employment and fitness checks had not been carried out to demonstrate that new and existing directors were fit and proper. The trust had implemented a new governance framework in December 2013 and we found that there was no process in place to provide assurance to the board that this framework was effective. **Governance, risk management and quality measurement** • The governance framework within the trust was very complex and processes were not effective to provide the board with assurance that its governance arrangements were effective. • Assurance to the board that there was an effective governance system in place was undertaken by it being monitored and reported through the trusts Board Assurance Framework (BAF).	

Summary of findings

- However, we found that the Board Assurance Framework had not been discussed at the Board since June 2014. This was contrary to the trusts risk management strategy where it is stated that the board will receive regular reports. Whilst we noted that the board had agreed for the audit committee to review the BAF we found that this document was not effectively scrutinized or challenged at that meeting. The discussions held in December 2014 at the audit committee regarding the BAF did not correlate to the BAF document. We were therefore not assured this was an effective way to provide assurance.
- We reviewed a number of the directorate level governance meeting minutes and found that these varied in quality. There was a lack of learning and improvement noted and also a lack of action setting or follow up to ensure continuous improvement.
- There was confusion at senior level about how oversight of the governance arrangements within the trust were monitored.The trusts new governance framework was implemented in in December 2013 and at the time of our inspection there was limited evidence to show the Board had reviewed its effectiveness. One internal audit had been made available to us which focused on the committee and reporting structure. This audit showed that there was a reporting structure through sub boards but not that there was any checking to ensure that the actual process was effective. When questioned the chair of the board did not demonstrate that they were aware of the internal audit taking place at the time of our inspection .Following our inspection we were provided with explanations which demonstrated processes were in place but these lacked formality and were not articulated to us during inspection.
- The risk management process was not clear; we were told the corporate risk register was discussed at the executive board meetings however found no reference to this in the minutes we reviewed. The trusts risk management strategy stated that the clinical safety sub-board was responsible for reviewing high level risks. Again we found lack of discussion and decision making with regards to high level risk in minutes of meetings that we reviewed.
- There was a clear clinical audit plan in place and from our review of the plan it was evident that the majority of audits for the current year had been completed, such as those required nationally and other more localised audits.
- We reviewed the National Institute of Clinical Excellence (NICE) implementation process. We found that a gap in assurance for this system had been identified previously. We noted that

improvements were being made and that regular monitoring now took place at the Clinical Standards Group which reported directly into a sub-committee of the board in order to provide assurance on the trusts compliance status with NICE guidance.

Leadership of the trust

- There was a disconnect within the leadership team at this hospital and this was felt throughout the entire trust. We spoke with a variety of staff members, ranging from executive and non-executive board members, senior and junior clinical staff and administrative and clerical staff who were all aware that the leadership team was not working effectively together. Whilst at the time of our inspection this was not seen to be impacting on patient safety or care in the specific areas we inspected, there is a risk that it will do so if it is not dealt with swiftly. Some members of the leadership team were not aware of the extent to which this disconnect was being felt.
- There was confusion and a conflict of priorities for the nursing workforce within the trust. This was because of the differentiating priorities and instructions coming from directorate director level and that of the nursing strategy. For example, line management for the senior nursing workforce was divided between two divisional directors and professional development was delivered by the Director of Nursing. This disempowered the role of the nursing director, and provided challenges to lines of accountability. The management structure should empower the director of nursing.
- We noted an absence of challenge at board and sub-committee level. From our review of six sets of minutes of the Board and six sets of sub-committee meetings we noted a lack of challenge and scrutiny at these meetings.
- A lack of management capacity had recently been identified by the trust following a series of external reviews. We saw that the management structure had been increased with the addition of four new deputy/associate director roles and a new executive post, the chief operating officer (COO). At the time of our inspection the COO had been in place for three days.
- Leaders were not cohesive about the role of the COO. There was no formal job description in place and the contracting agreement for this position was still being finalised at the time of our inspection. We were not assured that there had been clear and specific instruction from the Board about what they expected from the role and how it should impact on service delivery.

- There was also a lack of unity from within the leadership team about the trusts priorities. We asked all members of the team to identify what they believed the top three risks for the organisation were and we did not receive a consistent response.
- The trust had not been meeting some of its performance targets for a sustained period of time; this was specifically in relation to referral to treatment times, cancer wait times and A&E performance. Whilst there was cohesion from the Board about the actions in place to address these areas there was a lack of formal improvement planning and monitoring. For example, we could not be provided with an action plan which demonstrated that monitoring of actions had taken place in the three months preceding our inspection. Improvement plans could not be provided to us. We found there was a lack of forward planning within the team and plans described to us were short term and reactive. We were therefore not confident in the sustainability of the trusts ability to deliver improvement.

Culture within the trust

- Prior to and during our inspection we received allegations that staff were being bullied in order to meet performance objectives. It was also alleged that this had emanated from within the leadership team at this trust. We had received three notifications prior to our inspection and were informed directly on 13 different occasions during our inspection.
- Five members of staff reported that they had felt pressure by members of the leadership team to fast track projects without due care and attention. There was also feeling within the trust that targets were being placed before patient safety.
- Some concerns had been raised directly with members of the Board, however we were not confident robust plans were in place to deal with these effectively. From our discussions with some of the leadership team we noted a lack of insight and understanding on the gravity of the concerns raised. Formal processes had not been followed and there were no clear plans in place as to the measurement of improvement. At the time of our inspection the concerns within the management team had been known for three months and no improvements or identified clear action plans were in place.
- The non-executive directors had commissioned an external review of the working dynamics and effectiveness within the executive team. This report reiterated our findings regarding the disconnect within the executive team, including negative

relationships and lack of cohesion and teamwork. We have not been assured by the responses given from the Trust that a robust process or action plan is in place to address this situation.

- Three members of staff told us that they felt fearful of raising concerns or whistleblowing internally and this was also reported to us anonymously twice prior to our inspection. We were told that they felt they would not be listened to or that they would be reprimanded for speaking out. On more than one occasion we were informed that raising concerns was seen as obstructive and staff gave examples of being ostracised having raised concerns“ until they became useful again” .
- The trusts most recent staff survey (2014) corroborated our findings with the percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months being 29% which was 6% higher than the national average and placed the trust in the worst 20% of all trusts. 44% of staff also reported that they had suffered from work related stress in the past year. This was a significantly negative change since the 2013 survey and again the score was within the worst 20% of all trust.
- Initial steps, such as staff listening events had been taken by the leadership team in order to address the culture within the wider trust. However at the time of our inspection, there were no clear plans to measure improvement.

Fit and Proper Persons

- At the time of our inspection the trust had not considered the arrangements it needed to put in place in order to demonstrate that it met the requirements of the fit and proper person regulation. - This came into force on 27 November 2014. The intention of this regulation is to ensure that people who have director level responsibility for the quality and safety of care are fit and proper to carry out this important role.
- We reviewed the staff files of all of the executive board and those staff performing the functions of directors (8 in total) and the non-executive board (6 in total). We found that appropriate employment or fitness checks could not be evidenced fully in any of the 14 files reviewed or upon request.
- We also found a lack of decision making present regarding the appointment of new directors for example there was no additional record made of any process or discussions in order to deem an individual was suitable.

Overview of ratings

	Safe	Effective	Caring	Responsive	Well-led	Overall

Outstanding practice and areas for improvement

Areas for improvement

Action the trust MUST take to improve

Action the trust MUST take to improve

The trust must ensure that it has effective arrangements in place to ensure that all directors, or those performing the functions of a director, are fit and proper in line with regulation 5 of the Health and Social Care Act **Health and Social** Care Act 2008 (Regulated Activities) Regulations 2014.

The trust must review its governance arrangements to ensure that sufficient assurance is give to the board on the effectiveness of such arrangements

Action the trust SHOULD take to Improve

The trust should consider how the disconnect within the leadership team is impacting the running of the hospital and develop measureable plans to demonstrate a clear and unified direction of travel.

The trust should ensure that appropriate and swift action is taken to address the bullying culture which is alleged to be present within the trust and ensure effective monitoring and follow up takes place.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not established and operated effectively to enable the provider to assess, monitor and improve the quality and safety of the service provided or to mitigate the risks relating to the health safety and welfare of service users and others who may be at risk. Regulation 17 (1) (2) (a) and (b).