

Norfolk and Norwich University Hospitals NHS  
Foundation Trust

# Norfolk and Norwich University Hospital

## Quality Report

Colney Ln, Norwich, NR4 7UY  
Tel: 01603 286286  
Website: [www.nnuh.nhs.uk](http://www.nnuh.nhs.uk)

Date of inspection visit: 4th, 5th and 20th April 2017  
Date of publication: 10/08/2017

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

# Summary of findings

## Letter from the Chief Inspector of Hospitals

The Care Quality Commission (CQC) carried out this inspection on 4th, 5th and 20th April 2017. We undertook this inspection due to a number of whistle blowing contacts from staff in relation to regular movement of staff between wards to fill gaps in rotas, insufficient staff in some areas including medical wards, maternity and children's services and allegations of bullying. At this inspection we found that some of these concerns remained amongst some staff groups we spoke with. However, progress had been made by the trust in recruiting additional nursing staff and used other staff to mitigate risks to patients. Information also showed a poor performance in some referral to treatment times and 5 never events reported between February 2016 and January 2017.

This inspection examined the key questions of safe, responsive and well led in medicine, surgery and children's and young people services. We looked at all key questions (including effective and caring) in maternity and gynaecology.

We carried out a comprehensive inspection at Norfolk and Norwich University Hospital NHS Trust in November 2015 when the trust was rated as requires improvement.

The 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 provides a full range of acute clinical services plus further private and specialist services. The Trust has 913 acute beds, 210 day case beds and provides care for a tertiary catchment area of up to 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 in partnership with the University of East Anglia, University Campus Suffolk and City College Norwich.

Since our last inspection the trust had recruited further substantive executives and had no interim executives on the board. Whilst we found the trust had met our previous requirement notices for some concerns we had previously raised, they had failed to meet the requirement notices or make significant progress in the management of medicines and staff mandatory training.

Our key findings were as follows:

- There had been a change in the operational structure at the hospital since our last inspection. There were now 4 divisions, the clinical divisions being headed by a chief of division, operations director and nurse director.
- The attitude of staff remained excellent. All staff were helpful, open and caring in their manner. We found staff to be very 'upbeat' locally within ward and clinical teams.
- There were examples of excellent leadership in the areas we inspected. Some had an excellent understanding of their area and were driven and committed in leading their teams to provide excellent care.
- Whilst we only inspected effectiveness in maternity, we saw good examples of multidisciplinary working between clinical and non clinical staff in ward areas.
- We have seen good overall improvements in maternity services.
- Some good examples of record keeping were seen through ward and clinical areas.
- Staff demonstrated a good knowledge of safeguarding principles though training levels for staff were well below trust target in some areas.
- Mandatory training compliance was variable across the trust but in most of the areas we inspected, compliance was well below trust target.
- Staff told us that concerns or positive ideas for improvement are reported to senior managers but whilst they felt these were listened to by their immediate managers it was lost in the ether above those managers.

# Summary of findings

- Staffing at night remained a challenge with wards having less nursing cover than planned and frequent of movement of staff between wards to manage shortfalls of shifts. Staff also raised concerns regarding skill mix particularly when staff were moved to other wards at night.
- A number of staff told us that they felt “bullied” to take patients that they felt were not appropriate for their area. This was predominantly out of hours. Matrons were able to advocate for junior staff during the day but when not available, staff felt under increased pressure to take these patients. We had a positive discussion about this with the trust and what they were doing to address these issues. The site team felt under pressure themselves from ward staff.
- We found that staff were not always following policies, for example we found that emergency resuscitation equipment was not always checked daily and that fridge temperatures including those in theatres were not always checked and recorded. There was ongoing poor mandatory training compliance across the areas we inspected.
- Almost all staff we spoke with were unaware of the speak up guardians at the trust. Some had used the whistleblowing/ speak up policy but experience of it was variable. Some felt it had worked and supported them others that it had not.
- Ward staff report the executive team as not being visible in ward or clinical areas.
- We found that quality checks on the WHO surgical safety checklist were not being completed; this despite there being four never events within the surgery service.

We saw several areas of outstanding practice including:

- The children and young people’s service was proactive in clinical research. There were a large number of active research studies being undertaken throughout the children and young people’s service. This meant that the service was at the forefront of clinical innovation.
- The hospital received funding January 2017 following a successful bid to the Department of Health’s Maternity Innovation Fund and the Maternity Safety Training Fund to provide additional training for staff. The Maternity Innovation Funding was for a new piece of simulation technology called ‘CTGi’ which replicates a baby’s heart rate pattern during labour. This piece of training technology will be used within clinical areas for both the midwifery and medical teams and supplement more traditional class room tutorials and e-learning programs.
- The trust was about to launch the ‘Baby University’ scheme. Every new or expectant mum that signs up for the scheme will receive a Baby Box made from a very thick cardboard, a firm foam mattress, waterproof mattress cover and a cotton sheet. The scheme replaces the need for a traditional Moses basket or cot, and it is thought the small size of the Baby Box helps to prevent sudden infant death syndrome.
- Cley gynaecology ward had a bereavement baby memento bag/box for parents, which contained a form to acknowledge the existence of a foetus born before it was viable (as a birth certificate could not be issued) and tiny hand knitted garments for stillborn babies to have photographs for parents.

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

Importantly, the trust must:

- The trust must ensure that medication is stored in line with trust policy and that staff record medication refrigeration temperatures to ensure the safe storage of refrigerated medication.
- The trust must ensure that resuscitation equipment in wards, theatres and other areas is checked in accordance with trust policy.
- The trust must ensure that patient records are stored securely.
- The provider must ensure staff complete appropriate mandatory training including safeguarding training to an level appropriate to their job role.

In addition the trust should:

- Ensure that there are adequate medical and nursing staff and an appropriate skill mix to care for patients in line with national guidance.

# Summary of findings

- The provider should ensure they regularly undertake observational audits or measurement of the quality of the World Health Organisation (WHO) five steps to safer surgery checklists and action any lessons learnt.
- The trust should ensure it meets the referral to treatment time for specialities that do not meet the England average such as gynaecology.
- Ensure staff follow infection prevention and control procedures and do not leave side room doors open when they should be kept closed to minimise the spread of infection.
- The trust should ensure that maternity electronic discharge information is sent to general practitioners within 24 hours of discharge.
- The trust should consider how they provide community midwives with access to information technology.
- Review access to transitional beds for young people aged 16 to 18.
- Ensure clinical staff receive training in sepsis protocols and procedures.
- Ensure that staff caring for children in non-paediatric areas have appropriate safeguarding and resuscitation training.
- Ensure morbidity and mortality meeting minutes include sufficient detail of background information, discussions and those in attendance.
- Review the children's assessment unit to address admission times, infection control concerns, and distance to transfer acutely unwell children from the emergency department.
- The trust should ensure that it contributes to the national Maternity Safety Thermometer.
- Review and ensure the effective management of community midwifery staff.

**Professor Edward Baker**

**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

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

### Rating Why have we given this rating?

- Medicines were not always stored safely in line with trust policy and the temperature of medication requiring refrigeration was not always checked.
- Staff did not carry out routine checks on resuscitation equipment.
- Staff compliance with mandatory training, including safeguarding was below the trust target.
- Most of the wards we visited had vacancies for either registered nurses (RN) or health care assistants (HCA). The vacancy rate across medical wards was 14%.
- Staff raised concerns regarding the length of time the trust had been operating with two doctors in training positions rather than three within the medicine division. The trust informed us that the establishment was for two with a third booked to support. The third position was to become permanent in August 2017.
- We spoke with a number of junior doctors, who were unhappy with the working shift rota and working hours.
- For medical non-elective patients, the average length of stay was 7.2 days, which is higher than England average of 6.7 days.
- The following specialties were above the England average for admitted Referral to Treatment Times (RTT) (percentage within 18 weeks), neurology, geriatric Medicine, rheumatology, and dermatology.
- The majority of staff we spoke with on the wards were unaware of any local vision or strategy held by the trust in relation to the medical division.
- Some staff felt there was a lack of senior leadership within the medical division.
- The majority of staff we spoke with said they hardly ever saw the directors on the ward areas. Some staff said they saw them infrequently at bed meetings, but most agreed that the senior team members were not visible.

# Summary of findings

- Not all medical and nursing staff we spoke with during our inspection knew medical division risks were held on the electronic system.
- Some staff felt there was unnecessary pressure placed on them to take and discharge patients from the wards and that at times this was uncomfortable for them to manage.

## However:

- Staff knew how to report incidents and deal with complaints and there was a learning culture within the medicine division.
- There were clear procedures for managing and referring safeguarding concerns in relation to children and adults who may be at risk of abuse. Staff we spoke with knew how to make a referral and who to refer their concerns to within the trust.
- We reviewed 21 patient records and found all risk assessments were completed, early warning scores (EWS) and risk assessments clearly documented.
- Staff adhered to the trust hand hygiene and 'bare below the elbow' policy, and wore personal protective equipment such as gloves and aprons during care.
- Staff used early warning scores (EWS) on the medical wards to monitor and identify any deteriorating patients. All records we reviewed showed that staff routinely completed EWS and alerted senior staff to any patient that may be deteriorating.
- Between November 2015 and October 2016, the average length of stay for medical elective patients at the trust was 2.9 days, which is lower than England average of 4.1 days.
- We saw significant improvements in the Acute Medical Unit Men (AMUM) and Acute Medical Unit Ladies (AMUL) performance due to changes in the physical environment.
- Patients living with dementia and those who had suffered a stroke had "This is me." documentation in place. The division had a dementia strategy and delirium strategy in place and supported by a dedicated dementia team.

# Summary of findings

- The speech and language therapy (SaLT) team saw patients who had had a stroke promptly to reduce the time patients spent nil by mouth.
- If patients had complex needs or required additional family support, staff made special arrangements regarding visiting and access to patients outside of normal visiting hours
- The trust had significantly invested in the recruitment of discharge co-coordinators who worked across the wards to promote the safe and timely discharge of patients.
- All staff we spoke with knew how to report a complaint and that feedback from complaints would be shared on a one-to-one basis where necessary or via team meetings.
- There were several established systems to ensure good clinical governance and monitor performance.
- The majority of staff we spoke with felt supported and valued by their direct line manager.
- Junior nurses we spoke with told us that the medical division was a good place to start their career.

---

## Surgery

- The trust reported four never events between February 2016 and January 2017.
- There were no local observational audits or measurement of the quality of the World Health Organisation (WHO) five steps to safer surgery checklists.
- Staff did not follow infection prevention and control procedures. Staff, on Gissing and Earsham ward, left side room doors open when they should have been closed to prevent the spread of infection.
- Medicine management was not in line with trust policy.
- There were examples of poor storage and security of patient medical records.
- Nurse staffing did not reflect the acuity of patients on some of the surgical wards. There was a high number of nursing vacancies and

# Summary of findings

gaps in working rotas were frequently filled with healthcare assistant hours. We were concerned that staffing shortfalls could impact on patient care.

- Resuscitation equipment on the wards and was not adequately checked and maintained.
- Staff compliance with some aspects of mandatory training such as safeguarding were well below trust target.
- Patients were frequently delayed in theatre and the number of bays available in recovery was not in line with guidance from the Department of Health. Health building note (HBN) 26 Facilities for Surgical Procedures states there should be two recovery bays for every theatre. We saw there were 16 adult bays for 17 theatres.
- The trust had cancelled 2,647 procedures between quarter 4 2014/ 15 and quarter 3 2016/ 17, 20% of these patients were not treated within 28 days.
- Staff morale was low within the surgery division with staffing and clinical pressures contributing factors. A shortage of medical beds throughout the hospital meant that ward staff felt pressurised to take patients who were not suitable for their ward areas and there was a lack of communication between the ward and the board.

## However:

- Staff reported incidents and were knowledgeable about the incident reporting process.
- The trust had clear processes and procedures in place for safeguarding.
- Ward areas were visibly clean, with appropriate equipment and facilities for hygiene and infection control. Staff accessed equipment such as hoists and scales that were serviced and checked in line with policy.
- Staff completed patient care records legibly and signed and dated entries.
- There had been an improvement in referral to treatment times in the division since the beginning of 2017.

# Summary of findings

- One stop clinics were available for hand and cystoscopy surgery patients and the day patient unit (DPU) was proactive in reducing patient admissions.
- Translation services were available and patient information leaflets were available in different languages and formats.
- There was evidence of learning from complaints in the form of “you said we did” posters.
- Staff we spoke with knew the vision and values of the trust and junior staff felt supported by their ward managers. Most ward staff felt they had a good team.
- Ward managers and surgical matrons attended monthly surgical governance meetings. There was evidence that the ward team discussed their performance around the quality indicators used at the trust.
- The trust had a plan to develop, refurbish and expand the high dependency unit and develop level one beds on Gissing ward. Staff we spoke with knew about the plan and how it would impact them.

## Maternity and gynaecology

### Requires improvement



We rated this service as requires improvement because:

- Incidents were not always classified in line with trust policy.
- Controlled medicines were not always checked and stored safely.
- Patient records were not stored securely and records audits indicated continued poor compliance in some areas.
- Resuscitation equipment was not always checked regularly in line with trust policy.
- Mandatory and safeguarding training were below the trust targets.
- Electronic discharge letters were not always sent within 24 hours meaning women’s general practitioners were not informed of their hospital stay and outcome.
- Community midwives did not have access to information technology, although this was in the process of being addressed there was no time schedule yet.

# Summary of findings

- Patient outcomes were similar to the England average, but maternity dashboard outcomes such as the percentage of women breastfeeding at discharge, readmissions within 30 days and admissions to critical care unit consistently failed to meet targets.
- The gynaecology service did not meet its referral to treatment (RTTs) waiting times. There were 2543 patients on the gynaecology 18 week RTT incomplete waiting list and a backlog of 617 patients waiting up to 45 weeks for treatment.
- There was a lack of ownership at ward management level of issues such as checking resuscitation equipment, ward cleaning and medication checking.

## However:

- There have been significant improvements in the investigation of incidents with staff given training and protected time to investigate.
- Midwifery staffing had improved since the previous inspection, and hospital midwifery staff were over establishment to accommodate leave.
- Staff provided care according to national guidance and evidence based practice and where they were not using guidance they risk assessed, reviewed and worked towards compliance.
- Staff contributed to a number of national audits and performed a range of local audits to improve women's care and shared results.
- Women we spoke with were very positive about their treatment by all clinical staff and the standard of care they had received.
- Women were involved in their choice of birth at booking and throughout the antenatal period. In antenatal clinics, women were given information regarding different birthing settings early on in their pregnancy, including the benefits and risks of home birth.
- Services were planned, delivered and co-ordinated to take account of women with complex needs, there was access to specialist support and expertise from medical and nursing and midwifery staff.

# Summary of findings

- There was strong leadership demonstrated from the senior management team, with a clear vision and strategy for the maternity service.
- The senior management had oversight of clinical risks and there was evidence that risks were regularly reviewed and updated with named ownership of risks.
- There was a strong drive to improve and develop with multiple innovations including the development of the IT system, and the Baby University scheme.

## Services for children and young people

- Patient care records were clear, detailed, and contained all necessary information.
- Additional security measures had been introduced throughout the children and young people's service. All areas were found to be secure during our inspection. This addressed concerns raised during our previous inspection.
- Staff were knowledgeable about the incident reporting process. There was evidence of learning and communication to staff regarding outcomes of investigations.
- Staff across the children and young people's service were knowledgeable about the complaints process. Staff gave us examples of complaints that had led to changes in practice.
- The service was planned and delivered to meet the needs of local people. For example, accommodation was available for parents to stay on the neonatal unit and an outreach team supported the discharge process.
- The service met the individual needs of patients, including those in vulnerable circumstances. For example, there were support groups and a family care coordinator for parents on the neonatal unit.
- An electronic bed booking system had been introduced on the children's day ward to improve list utilisation.
- A paediatric flow coordinator role was introduced in April 2017. This role would support patient flow throughout the children and young people's service.
- A child and adolescent mental health service (CAMHS) was introduced in April 2017 and was

# Summary of findings

available seven days a week, meaning that children and young people suffering from mental health problems could be assessed on the same day as their admission.

- Staff described a positive and open culture with approachable and visible local leadership in the children and young people's service.
- The majority of staff demonstrated an awareness of the trust vision and values.
- Action had been taken to address some of the concerns that were identified on our last inspection. For example, additional security measures had been introduced across the service, cytotoxic waste was now being segregated and disposed of appropriately, and a bank healthcare assistant was being used on the children's day ward.
- Senior leaders were well sighted on the risks in the division. There was a clear strategy in place for the development of services.
- There were regular governance and quality meetings within the division with good attendance from staff.
- Staff were increasingly given an opportunity to contribute to the direction and strategy of the division.

## However:

- Only 16% of incidents were reported to the National Reporting and Learning System (NRLS) within 60 days.
- Checks of resuscitation equipment were inconsistent.
- Mandatory training compliance was below the trust target of 95% in February 2017. Compliance rates for medical staff (67.1%) were much lower than for nursing staff (86.9%).
- Registered nursing staffing levels regularly fell below basic levels on Buxton ward and healthcare assistants were used to increase staffing numbers when this occurred.
- There were insufficient numbers of qualified staff to fill the rota to the recommended levels for the four paediatric high dependency unit (HDU) beds

# Summary of findings

on Buxton ward. In the interim, practice educators, the ward sister and staff with relevant experience but no HDU qualification were used to support the rota.

- Consultant cover in the children's assessment unit did not meet national guidance. However, consultant cover had been increased from previous levels and a CAU improvement project was underway at the time of our inspection, which included a review of the level of consultant cover.
- Cohort nursing, where infectious patients are treated together in one area away from other patients, was practiced on the children's assessment unit due to the lack of side room availability. This presented an increased risk of cross infection. However, an integrated performance report showed that daily audits were undertaken as a monitoring precaution.
- Paediatric surgery and neonatal mortality and morbidity meeting minutes lacked detail and this limited the opportunity for shared learning with those unable to attend. It was not clear who attended meetings as only initials were recorded and the minutes for the February 2017 surgery meeting appeared to indicate that only one person was in attendance.
- The children and young people's service had lost access to four transitional beds for young people aged 16 to 18.
- There were increased admission times on the children's assessment unit (CAU) due to an increasing number of attendees with no increase in bed spaces.
- Referral to treatment time (RTT) was not met consistently across all sub-specialties, meaning that children were not always treated within 18 weeks of referral.
- Staff said that they rarely or never saw the director of nursing or the executive team.
- Staff said that there was a lack of out-of-hours management support on Buxton ward.
- The risk register did not reflect all of the risks identified on our inspection. For example, the inconsistent checks of resuscitation equipment

# Summary of findings

---

and children being admitted onto non-paediatric wards where staff were not always appropriately trained in safeguarding or paediatric resuscitation.

- A number of the concerns identified during our previous inspection had not been addressed. For example, mandatory training compliance levels, inconsistent checks of emergency resuscitation equipment, and nursing staffing levels.
-

# Norfolk and Norwich University Hospital

## Detailed findings

### **Services we looked at**

Medical care (including older people's care); Surgery; Maternity and Gynaecology; Services for children and young people.

# Detailed findings

## Contents

### Detailed findings from this inspection

	Page
Background to Norfolk and Norwich University Hospital	16
Our inspection team	16
How we carried out this inspection	17
Facts and data about Norfolk and Norwich University Hospital	17
Our ratings for this hospital	17
Action we have told the provider to take	87

## Background to Norfolk and Norwich University Hospital

The Norfolk and Norwich University Hospital is an established 1237 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 status of Foundation trust was achieved in May 2008. The Trust is one of the largest teaching hospitals in the country. The Trust operates from a large purpose built site on the edge of Norwich and from a smaller satellite at Cromer in North Norfolk.

The majority of patients live in Norfolk, North Suffolk and Waveney, however tertiary services are provided beyond these boundaries. The Trust has the largest catchment

population of any acute hospital in the East of England. The main University hospital is strategically placed adjacent to Norwich Research Park and the A47. It offers a high quality environment with facilities constructed and operated through the PFI initiative and was completed in late 2001.

This trust is registered for the activities of:-

Treatment of disease disorder or injury.

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

Surgical procedures.

Diagnostic or screening procedures.

Management of supply of blood and blood derived products etc.

Maternity and midwife services.

Termination of pregnancies.

Family planning.

## Our inspection team

Our inspection team was led by:

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

The team included an inspection manager, 7 CQC inspectors, an assistant inspector and 5 specialists including 2 doctors, 2 nurses and a midwife.

# Detailed findings

## How we carried out this inspection

At this inspection we inspected the key questions of safe, responsive and well led in medicine, surgery and children's and young people's services. We looked at all five key questions (including effective and caring) in maternity.

Before visiting, we reviewed a range of information we held about the trust.

We spoke with a range of staff in the hospital, including nurses, junior doctors, consultants, administrative and clerical staff.

We talked with patients and staff from all the ward areas, operating theatres and other clinical areas. We observed how people were being cared for, talked with carers and/or relatives and reviewed patients' records of personal care and treatment.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Norfolk and Norwich University Hospitals NHS Foundation Trust.

## Facts and data about Norfolk and Norwich University Hospital

Norfolk and Norwich University Hospitals NHS Foundation Trust has two main locations

- Norfolk and Norwich University Hospital, a large acute hospital comprising all acute services.
- Cromer Hospital which offers surgical and outpatients' services.

The trust primarily serves a population of 822,500 people within the local catchment area in Norfolk and Norwich, as well as patients from further afield for the specialist services that it provides.

The trust's main commissioning CCG is NHS Norwich Clinical Commissioning Group.

- **Beds:** 1,237
  - 913 General and acute
  - 67 Maternity
  - 20 Adult Critical care of which
    - ITU - 10 beds
    - HDU - 10 beds

- Neonatal Intensive Care - 9 beds
- Neonatal High Dependency – 6 beds
- Paediatric HDU – 4 beds
- **Staff:** 6455
  - 953 Medical (against an establishment of 1057)
  - 1935 Nursing (against an establishment of 2221)
  - 3567 Other (against an establishment of 3962)
- **Revenue:** £543m
- **Full Cost:** £565m
- **Surplus (deficit):** (£22m)

### Activity summary (Acute) 2015/16

Inpatient admissions 211,934

Day case procedures 89,416

Outpatient (total attendances) 723,749

Accident & Emergency 120,062 (attendances)

There were 767,352 outpatient appointments.

## Our ratings for this hospital

Our ratings for this hospital are:

# Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	N/A	N/A	Requires improvement	Requires improvement	N/A
Surgery	Requires improvement	N/A	N/A	Requires improvement	Requires improvement	N/A
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Services for children and young people	Requires improvement	N/A	N/A	Good	Good	N/A

# Medical care (including older people's care)

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

## Information about the service

The medical care service at the trust provides care and treatment for nineteen medical specialties including; Geriatric Medicine, General Medicine, Cardiology, Respiratory Medicine, Neurology, Gastroenterology, Nephrology and Rheumatology.

The trust had 95,809 medical admissions between November 2015 and October 2016. Emergency admissions accounted for 29,576 (31%), 3,626 (4%) were elective, and the remaining 62,607 (65%) were day case.

Admissions for the top three medical specialties were:

- Gastroenterology: 24,805
- General Medicine: 22,014
- Clinical Oncology: 18,837

The trust has 566 medical inpatient beds and 40 day-case beds located across 16 wards. We visited 14 wards including Acute Medical Unit Men (M) and Women (L), Heydon, Knapton and Mattishall wards amongst others.

We used a variety of methods to help us gather evidence in order to assess and judge the medicine services at Norfolk and Norwich Hospital. We spoke with ten patients and relatives, 63 members of staff including nurses, doctors, therapists, a pharmacist, health care assistants, the head of acute medicine and non-clinical staff.

We also examined 21 patient records including records in relation to patient medication during this inspection. We observed the environment and the care of patients, and we looked at records, including patient care records. We also looked at a wide range of documents, including policies, minutes of meetings, action plans, risk assessments, and audit results.

## Summary of findings

- Medicines were not always stored safely in line with trust policy and the temperature of medication requiring refrigeration was not always checked.
- Staff did not carry out routine checks on resuscitation equipment.
- Staff compliance with mandatory training, including safeguarding was below the trust target.
- Most of the wards we visited had vacancies for either registered nurses (RN) or health care assistants (HCA). The vacancy rate across medical wards was 14%.
- Staff raised concerns regarding the length of time the trust had been operating with two doctors in training positions rather than three within the medicine division. The trust informed us that the establishment was for two with a third booked to support. The third position was to become permanent in August 2017.
- We spoke with a number of junior doctors, who were unhappy with the working shift rota and working hours.
- For medical non-elective patients, the average length of stay was 7.2 days, which is higher than England average of 6.7 days.
- The following specialties were above the England average for admitted Referral to Treatment Times (RTT) (percentage within 18 weeks), neurology, geriatric medicine and rheumatology.
- The majority of staff we spoke with on the wards were unaware of any local vision or strategy held by the trust in relation to the medical division.
- Some staff felt there was a lack of senior leadership within the medical division.

# Medical care (including older people's care)

- The majority of staff we spoke with said they hardly ever saw the directors on the ward areas. Some staff said they saw them infrequently at bed meetings, but most agreed that the senior team members were not visible.
- Not all medical and nursing staff we spoke with during our inspection knew Changed to medical division risks held on an electronic system.
- Some staff felt there was unnecessary pressure placed on them to take and discharge patients from the wards and that at times this was uncomfortable for them to manage.

However:

- Staff knew how to report incidents and deal with complaints and there was a learning culture within the medicine division.
- There were clear procedures for managing and referring safeguarding concerns in relation to children and adults who may be at risk of abuse. Staff we spoke with knew how to make a referral and who to refer their concerns to within the trust.
- We reviewed 21 patient records and found all risk assessments were completed, early warning scores (EWS) and risk assessments clearly documented.
- Staff adhered to the trust hand hygiene and 'bare below the elbow' policy, and wore personal protective equipment such as gloves and aprons during care.
- Staff used early warning scores (EWS) on the medical wards to monitor and identify any deteriorating patients. All records we reviewed showed that staff routinely completed EWS and alerted senior staff to any patient that may be deteriorating.
- Between November 2015 and October 2016, the average length of stay for medical elective patients at the trust was 2.9 days, which is lower than England average of 4.1 days.
- We saw significant improvements in the Acute Medical Unit Men (AMUM) and Acute Medical Unit Ladies (AMUL) performance due to changes in the physical environment.

- Patients living with dementia and those who had suffered a stroke had "This is me." documentation in place. The division had a dementia strategy and delirium strategy in place and supported by a dedicated dementia team.
- The speech and language therapy (SaLT) team saw patients who had had a stroke promptly to reduce the time patients spent nil by mouth.
- If patients had complex needs or required additional family support, staff made special arrangements regarding visiting and access to patients outside of normal visiting hours.
- The trust had significantly invested in the recruitment of discharge co-coordinators who worked across the wards to promote the safe and timely discharge of patients.
- All staff we spoke with knew how to report a complaint and that feedback from complaints would be shared on a one-to-one basis where necessary or via team meetings.
- There were several established systems to ensure good clinical governance and monitor performance.
- The majority of staff we spoke with felt supported and valued by their direct line manager.
- Junior nurses we spoke with told us that the medical division was a good place to start their career.
- Senior leaders in the division had a clear strategy for the division and were sighted on risks and challenges.

# Medical care (including older people's care)

## Are medical care services safe?

Requires improvement 

We rated safe as requires improvement because:

- Medicines were not always stored safely in line with trust policy and the temperature of medication requiring refrigeration was not always checked.
- Staff did not always carry out routine checks on resuscitation equipment.
- Staff compliance with mandatory training, including safeguarding was below the trust target.
- Most of the wards we visited had vacancies for either registered nurses (RN) or health care assistants (HCA). The vacancy rate across medical wards was 14%.
- We spoke with a number of junior doctors, who were unhappy with the working shift rota and working hours.

However:

- Staff knew how to report incidents and deal with complaints and there was a learning culture within the medicine division.
- There were clear procedures for managing and referring safeguarding concerns in relation to children and adults who may be at risk of abuse. Staff we spoke with knew how to make a referral and who to refer their concerns to within the trust.
- We reviewed 21 patient records and found all risk assessments were completed, early warning scores (EWS) and risk assessments clearly documented.
- Staff adhered to the trust hand hygiene and 'bare below the elbow' policy, and wore personal protective equipment such as gloves and aprons during care.
- Staff used early warning scores (EWS) on the medical wards to monitor and identify any deteriorating patients. All records we reviewed showed that staff completed routinely completed EWS and alerted senior staff to any patient that may be deteriorating.

### Incidents

- Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and

should have been implemented by all healthcare providers. Between February 2016 and January 2017, the trust reported one incident that was classified as a 'Never Event' for Medicine.

- We reviewed the details in relation to the 'Never Event' and noted the trust had carried out a detailed investigation and made recommendations to minimise events like this again in the future.
- In accordance with the Serious Incident Framework 2015, the trust reported 75 serious incidents (SIs) in medicine that met the reporting criteria set by NHS England between February 2016 and January 2017. Of these, the most common types of incident reported were pressure ulcer meeting SI criteria, 29 (39%) and slips/trips/falls meeting SI criteria, 26 (35%).
- All staff we spoke with knew how to report incidents on the trust electronic reporting system and stated that they received feedback from any incidents via email or from their line manager and at team meetings. We also saw the monthly trust newsletter that gave feedback on various incidents and events.
- On the majority of wards we visited, the ward manager published learning from incidents on dedicated staff notice boards. Feedback on the incident included what went wrong, the method of reporting and all actions taken by the trust to prevent the incident again.
- The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. All nursing and medical staff we spoke with knew what the duty of candour was and that it was about being open and transparent when things go wrong.
- The trust held monthly mortality and morbidity meetings that included a wide range of multi-disciplinary support. The trust provided data of meetings from November 2016 to February 2017, which included appropriate information on reviews of individual cases including any learning outcomes shared amongst the staff team.

### Safety thermometer

- The safety thermometer is used to record the prevalence of patient harms and to provide immediate

# Medical care (including older people's care)

information and analysis for frontline teams to monitor their performance in delivering harm free care.

Measurement at the frontline is intended to focus attention on patient harms and their elimination.

- Data collection for the safety thermometer takes place one day each month, a suggested date for data collection is given, but wards can change this. Data must be submitted within 10 days of suggested data collection date.
- Data from the safety thermometer showed that the trust reported 69 new pressure ulcers, 32 falls with harm, and 21 new catheter urinary tract infections between February 2016 and February 2017.
- Except for a peak in August 2016, the prevalence rate for pressure ulcers reduced over time until December 2016 where it started to rise, peaking in January 2017. The prevalence rate for falls with harm remained steady over the period. The prevalence rate for catheter urinary tract infections was mixed during this period but prevalence appeared to be reducing over time.
- Dunston ward reported a grade two hospital acquired pressure sore on 4 April 2017, the root cause analysis was underway and staff had identified the pressure was due to the patient being seated for long periods out of bed. An action plan had been developed in response and was being managed locally.

## Cleanliness, infection control and hygiene

- Staff adhered to the trust hand hygiene and 'bare below the elbow' policy, and wore personal protective equipment such as gloves and aprons during care.
- Staff washed their hands in line with the World Health Organisation's "Five Moments of Hand Hygiene" guidance between personal care activities with patients and utilising the hand sanitiser where appropriate.
- Staff explained the protocol for patients with possible infectious disease and demonstrated they had good understanding of infection, prevention, promotion, and control in their day-to-day activities with patients.
- On the wards we visited details on identifying any infectious disease and how the public should notify staff was posted in prominent places.
- Hand sanitiser was available at the entrance to each ward area and clear signage was in place asking all staff and visitors to wash their hands and to follow the trust policy on infection prevention, protection, and control when entering or leaving wards or departmental areas.

- We were unable to visit Kimberly ward due to an outbreak of norovirus. Clear signage was in place warning staff and the public to be extra vigilant with handwashing and infection control if they entered this area.
- All wards we visited had an abundant stock of cleaning and sanitising equipment and key guidance for staff and patients on infection prevention, protection, and control was available at all hand washing areas.
- We spoke with two domestic staff that showed us cleaning regimes they followed in their day-to-day activities. Domestic staff continually engaged in cleaning activities, frequently emptied waste bins during the course of the day and the environments we visited were visibly clean.
- Domestic staff utilised green 'I am clean' stickers across the wards we visited stating that staff had cleaned and checked equipment and that it was clean and safe to use.
- The infection control team carried out hand hygiene and bedpan audits and produced certificates displayed throughout the wards. The audits on most wards showed above 90% compliance, with a number of wards being at 100% including Dunston ward, Elsing ward and Heydon ward amongst others.
- Nursing staff achieved 100% compliance with infection prevention and control training at level one and 84.2% at level two. Medical staff achieved 77.4% compliance with infection prevention and control training at level three. The trust compliance rate was 90%.
- On Hethel ward staff achieved 96% compliance with the cleaning audit, 100% with the commode and hand hygiene audit and 98% compliance with the dress code in February 2017.
- Staff carried out routine Methicillin-resistant Staphylococcus Aureus (MRSA) screening on both elective and non-elective patients within wards. In March 2017, Coltishall, Guist, Heydon and Knapton wards achieved 100% compliance with screening non-elective patients. Most wards achieved over 83% compliance with MRSA screening during the same period.

## Environment and equipment

- All wards we visited had controlled access in place at all times, to restrict unauthorised access into the ward areas. Staff kept a register of family members where

# Medical care (including older people's care)

patients required specific support from them on a routine basis. This allowed the family access to the ward at any time without staff constantly having to request their reasons for attending the ward.

- We examined equipment check labels to establish if staff checked equipment appropriately. In the main, we found staff checked equipment routinely.
- However, out of the eight resuscitation trolleys we inspected across the wards five were found to have routine checks missing during March and April 2017. On Guist ward, between 1 and 4 April 2017, staff did not carry out any checks on the resuscitation trolley. We spoke with staff about the omissions and staff told us it was often due to work schedules and prioritising the workload on each shift.
- Patient trolleys, equipment, and curtains providing privacy appeared visibly clean throughout the department. Curtains displayed an expiry check date and we found all curtains to be within the expiry date and in good condition.
- On Holt ward a cupboard containing items like razors, wipes, and pads was left open, despite a label on the door reminding staff to keep the door closed at all times.
- All wards utilised signage to identify the nurse in charge, the number of staff planned and actual staff on duty. Signage was clear and enabled staff, patients and relatives to see the number of staff on duty, identify staff roles, and see who was in charge of the department.
- Patient bays had clear signage to inform staff on entry if there were any specific issues, for example, if the patient was living with dementia, had a pressure area, or required hearing support. This enabled staff to identify any specific patient needs prior to entering the patient bays.
- At our last inspection in November 2015, we identified that Mattishall ward did not provide adequate patient safety or privacy. On our inspection, we found this ward renovated and staff said the ward was now a far better environment for patients and staff. However, they were still looking at any outstanding maintenance work required post renovation, for example, staff had no keys to cupboards and were unable to lock these.
- We noted on Cringleford ward that an assisted bathroom was being utilised as a store area. Staff had raised this as a concern and stated that the trusts own quality audits had identified this as an issue for concern. The room was overcrowded and the toilet sealed off

with a plastic cove. The environment was not acceptable for storage and ideally needed refurbishment to accommodate the safe storage of equipment and stock.

- Staff managed clinical waste in line with trust guidance. Domestic staff demonstrated how staff followed protocol for the disposal of clinical, non-clinical and recyclable waste. Waste bins were appropriately colour coded for the appropriate waste disposal method and we noted bins routinely emptied by domestic staff during our inspection.

## Medicines

- In this trust, 83% of medical staff and 87% of nursing staff within the medicine core service had completed mandatory training on medicines management. This was below the trusts target of 90%.
- On Knapton ward, we found the book for recording fridge temperatures was not present. We asked if staff could find the book, and staff told us it had been missing since March 2017. Staff reassured us they would order a new book as soon as possible. On Kilverstone ward, we found fridge temperatures routinely missed at the weekends.
- On all the wards we visited the controlled drugs records were legible and dated without any omissions and stored securely.
- Staff stored medication in locked rooms, neatly within cupboards and visibly clean. However, on Knapton ward we found these cupboards to be unlocked. Whilst the locked exterior door limited access, this meant if anyone was to enter the room using one of the main entry routes, they could easily access medication in an unlocked cupboard.
- The hospital carried out a routine quality assurance audit or quality round in December 2016 on Mulbarton ward. They found two drug trolleys not secured and left open, drug cupboards left unlocked and three patient drug pods left open. The audit also identified both medication fridge temperatures recorded but missed when the housekeeper was not on duty. The trust rated itself as requires improvement in this audit.
- On the acute medical units (AMU (M) male and AMU (L) ladies), the majority of the medication cupboards inside the locked storage areas were open. Staff explained they

# Medical care (including older people's care)

were purposefully left open to aid staff prepare medication for the lunchtime medications. However, there was no risk assessment available to support this process.

- We reviewed ten patient medication records on the trusts electronic medication system and found that all were accurate, and reflected the needs of the patients.
- We spoke with a pharmacist that demonstrated the trusts electronic medication system to us. They explained that the system limited errors and identified changes in patient medication, making it simpler for staff to record and identify patients who may be at risk from changes in medication or any omissions.
- Staff used workstations on wheels to administer medication rounds and utilise the electronic medications system. We observed medication rounds and found these to be well managed, calm and staff always carried out appropriate checks before dispensing or administering medication to patients.

## Records

- We reviewed 21 patient records as part of this inspection. Staff kept patient records either outside the patient's room, or at the end of the patient's bed and in a records trolley.
- Notes were accessible to all staff, however we did observe on a number of occasions records left open, on workstations on wheels or counters unattended.
- We noted that on occasion staff left the computer workstation on wheels logged in, so that patient's details were on the computer screen, without staff in attendance.
- Staff completed records to a very good standard, with complete risk assessments and reviews frequently during the patient's admission. Risk assessments included Early Warning Scores (EWS), Malnutrition Universal Screening Tool (MUST), Waterlow pressure scores, and falls risk assessments amongst others.
- We found good evidence of multidisciplinary team recording in patient records, to provide accurate details of care pathways needed to maintain patient wellbeing.
- The trust carried out an audit between March and February 2017, of the 'this is me' booklet aimed at supporting patients living with dementia. The audit identified that staff did not always use the booklet, in

August 2016, use was 35%, and this increased to 73.4% in September 2016. However, staff use of the booklet then fluctuated between 59.2% and 60.7% between October 2016 and February 2017.

## Safeguarding

- The trust has a target of 75% for completion of training on safeguarding of children. Within the medicine division, medical staff achieved 80% compliance with level one safeguarding children, and 80.8% with level three, both were above the trust target. Medical staff achieved 56% compliance with level two safeguarding children, which is below the trust target.
- Medical staff achieved 67% compliance with safeguarding adult's level two, which is below the trust target.
- Within the medicine division nursing staff achieved 100% compliance with level one safeguarding children, 78% compliance with level two and 87% compliance with level three, all above the trust target.
- Nursing staff achieved 89% compliance with safeguarding adult's level two, which is above the trust target.
- Between 1 October 2016 and 31 March 2017, staff raised 286 safeguarding adult alerts across all ward areas including, urgent an emergency care, AMU and acute care unit.
- There were clear processes and procedures in place for safeguarding adults and children. There were policies in place available to staff accessible through the trust's intranet system. Staff we spoke with knew how to recognise abuse and make a referral to the safeguarding leads for adults and children. Safeguarding referral guidance was available on wards and via the trust intranet system.

## Mandatory training

- The trust sets an internal target of 90% for all mandatory training. Medical staff achieved an overall compliance rate of 68% and nursing staff 78%, both below the trusts target.
- Data supplied by the trust showed medical staff compliance with mandatory training was in the main below the trusts 90% target. This included equality & diversity 68%, local fire Safety 73%, health & safety 82%, adult resuscitation 53% and medicines management 83%, amongst others. However, paediatric resuscitation was 95% which was above trust target.

# Medical care (including older people's care)

- Data supplied by the trust showed nursing staff compliance with mandatory training was in the main below the trusts 90% target. This included equality & diversity 89%, local fire Safety 86%, health & safety 88%, adult resuscitation 73% and medicines management 87% amongst other. However, paediatric resuscitation was 100%, which was above the trust target.
- All staff we spoke with said the trust offered training and they discussed this at appraisal and supervision. We noted on Kilverston ward that staff had set up additional specialist interest evenings, where staff could attend and receive updates on specific issues in relation to their practice.
- Data on the combined AMU showed 92% of staff completed equality and diversity training, 91% completed fire safety, and 95% completed infection, prevention, and control.
- On Elsing ward data showed 87% of staff completed medicines management and 69% infection, prevention and control, all below the trust target.
- On Knapton ward staff achieved 59% compliance with adult resuscitation training, 50% safeguarding children level two and 70% with safeguarding adults level two, all below the trusts target.

## Assessing and responding to patient risk

- Staff used early warning scores (EWS) on the medical wards to monitor and identify any deteriorating patients. All records we reviewed showed that staff routinely completed EWS and alerted senior staff to any patient that may be deteriorating.
- Data supplied by the trusts showed the percentage of falls with harm in February 2017 was 0.21%, which was below the average for other acute trusts at 0.41%.
- Guidance on the use of EWS and the Sepsis bundle was available at all staff workstations. All staff we spoke to were able to explain the escalation process for any patient seen to be deteriorating.
- Data on Elsing ward from February 2017 showed staff achieved 100% compliance with completion of core patient observations and 60% compliance with a repeat completed within an hour. On Hethel ward staff achieved 100% compliance with EWS during an audit in February 2017.
- Trust supplied data showing in quarter three across the medicine wards 93.2% staff repeated patient observations in response to EWS greater than four, within two hours of identification. Documented

intervention, action, and review by a registered nurse or a request for a doctor review was evident in 91.5% of these cases and there was documentary evidence that doctors attended in 98.1% of all these occasions.

- The trust provided a 24 hour, seven day a week acute stroke unit to ensure staff identified and monitored patients at risk appropriately.
- Staff held daily safety handovers that included discussions on patients at risk, where they were located in the hospital and actions required to manage any specific risks.
- Data supplied by the trust showed 43 inpatients initially admitted via the AMU were subsequently transferred back to the AMU from another inpatient ward between 1 March 2016 and 31 March 2017 rather than being discharged.

## Nursing staffing

- Senior nursing staff informed us that a nurse staffing audit took place every six months based on a recognised safer nursing care tool. The trust also encouraged safe staffing meetings on a monthly basis to enable staff to discuss any concerns in relation to staffing and patient acuity.
- Staff displayed the number of staff on duty both planned and actual at the entry to wards to enable staff, patients, and family members to see staffing levels on the ward. We checked all of these on the wards we visited and found they displayed accurate and up to date information.
- Staff assessed patient individual needs as part of the initial patient assessment process. Staff clearly documented the assessment that accurately reflected the patient needs and helped managers plan staffing levels based on patient acuity.
- Data supplied by the trust showed the majority of wards within the medicine division were below the required establishment figures. These included Cringleford ward, which was 3.9 whole time equivalent (WTE) lower than establishment, Elsing ward 8.7 WTE, Holt ward 11.2 WTE and Knapton 10.5 WTE. However, Kimberley ward was showing 3.8 WTE above establishment.
- Most of the wards we visited had vacancies for either registered nurses (RN) or health care assistants (HCA). Data seen during inspection showed the AMU having 8.8

# Medical care (including older people's care)

whole time equivalent (WTE) RN vacancies and 9.7 WTE unregistered nurse vacancies. The ward used agency or bank staff on a daily basis usually between 12 midday and 12 pm.

- Data supplied by the trust showed the average agency usage (including bank staff) was 11% across the medicine division between May and December 2016.
- In November 2016, Mattishall ward staffing was 278.2%, Holt ward 226.1%, Elsing ward 203.4%, and Mulbarton ward 162.7%. However, this was additional staff usage for example for patients requiring one to one care and support and was frequently filled by bank or agency staff. During the same period Hethel ward used 129.9%. Most wards were routinely above 60% agency usage during the same period, with the exception of Cringleford ward, which was 19.6%.
- Hethel ward data showed it had 5.5 WTE RN vacancies, a six-hour trainee vacancy, an 11.5 hours band two vacancy and 24 hours band four vacancy.
- The hyper acute stroke unit (HASU) nurse staffing did not meet guidance Royal College of Physicians: National clinical guideline for stroke. We had identified this at our last inspection in November 2015. On this inspection most patients being cared for in the HASU were not in the immediate acute phase of stroke. Two patients were about to be discharged home directly from the unit and the acuity of patients was low. There were no recorded incidents related to staffing in the HASU.
- Dunston ward had two health care assistants below the required staffing levels on the first day of our inspection due to staff sickness, and data on the ward showed 11 WTE RN vacancies. Guist ward was above its expected staffing levels on the second day of our inspection and had an additional RN and HCA due to the acuity of patients.
- Data provided by the trust showed the medicine division had a 14% vacancy rate for nursing staff.
- Data provided by the trust showed the medicine division used 11% agency and bank staff on average each month between May and November 2016. The highest agency and bank staff use was 14% in both July and August 2016. The use of agency and bank staff never fell below 8% between May and November 2016 and ranged between 8% and 13% during this period.
- Data provided by the trust showed variable staff turnover rates across the medicine division with an average 9.9%. Staff turnover rates on individual wards varied greatly, but the majority were below the 9.9%

average. These included Brundall ward 6%, Dunston Ward 6%, Cringleford, Knapton, and Guist who were all 0%. However, Holt ward was 38%, Elsing ward 15% and Heydon 12% all above the 9.9% average. Employee turnover refers to the proportion of employees who leave an organisation over a set period expressed as a percentage of total workforce numbers.

- Data provided by the trust showed variable sickness rates across the medicine division. Sickness absence rates on individual wards varied greatly, but the majority were below the 4.1% average. These included Mattishall ward 15.1%, Knapton ward 11.9%, Cringleford 10.7%, Elsing ward 8.1%, Heydon ward 6.2%, Hethel ward 5.9%, Brundall ward 5.7%, Holt 5.5% and Dunston at 4.8%. The AMU combined sickness absence rate was 3.4% and Guist ward 2.7%, which were below the trust average.
- Data supplied by the trust showed 71 incident reports made by staff in relation to concerns regarding staffing levels across the medicine wards between November and December 2016.
- We observed staff handovers; this was comprehensive, involved various nursing, multidisciplinary and medical staff and covered a wide range of topics focused on patient safety, flow and discharge.

## Medical staffing

- Between 1 November 2016 and 30 November 2016, the proportion of consultant staff and junior (foundation year 1-2) staff reported to be working at the trust were about the same as the England average.
- Data provided by the trust showed the medicine division had an 11% vacancy rate for medical and dental staff.
- We spoke with a number of junior doctors, who were unhappy with the working shift rota and working hours. They reported being exceptionally busy and we identified three training grade doctors covering a rota, designed to have eight covering the rota.
- Information shared by the trust following our inspection stated that the registrar rota is changing on the 14 May 2017 to a one in 14 nights shift rota and senior house officer rota changing in August 2017 to a one in twelve rota. Each ward also has Registrar cover, on a rotational basis.
- Doctors told us that they struggled to plan annual leave due to the constraints of the rota, and that speciality registrars would have to cover any gaps in the rota.

# Medical care (including older people's care)

- Staff raised concerns regarding the length of time the trust had been operating with two training grade doctors rather than three. The trust told us that the establishment was for two and that a third was booked to support. The third was to become a substantive in August 2017.
- The sickness absence rate amongst medical and dental staff within the medicine division was 1.1% and the staff turnover rate was 8.3%.
- The AMU had four consultants covering at any time, and consultant specialist physicians, on a general medical on call rota, supplemented the on-call system. There was a minimum of one registrar on duty at any one time, an overnight on-call registrar. The trust had recently recruited 7 further registrars to support the teams in the AMU's.
- In the stroke service, a consultant was on call for thrombolysis. Patients received a registrar review every day and a consultant review twice weekly on a full consultant rota.
- Every week the Diabetes and Endocrinology consultants do what they call a seven - seven rota (a week of seven day cover on the ward one in every seven weeks) They cover the ward and are on call for the full 7 days. This runs Monday to Sunday and staff say this works really well as the patients have good continuity of care and so does the ward. The consultant carries an internal DECT phone if the ward needs them outside of the ward round. There has been a consultant vacancy from mid-February 2017, the other consultants have covered this section of seven-seven rota, and there have been no significant gaps in the rota.
- On Guist ward consultants cover the ward in three teams, the inflammatory bowel disease (IBD team), nutrition team, and liver team and there is always a member from each team covering the ward.
- In the majority of clinical areas, consultant medical staff reviewed patients twice weekly, with registrars reviewing patients on a daily basis.
- Handovers were comprehensive and included reviews of any patients deemed as high risk.

## Major incident awareness and training

- The medical division had a major incident plan and business continuity plan in place to deal with any incidents likely to disrupt or have significant impact on its services.

- Nursing staff we spoke with were aware of the processes they should follow and actions required in the case of a major incident being declared across the trust.

## Are medical care services responsive?

Requires improvement 

We rated responsive as requires improvement because:

- The following specialties were below the England average for admitted referral to treatment time RTT (percentage within 18 weeks), gastroenterology, thoracic medicine, and cardiology and had been below the England average since October 2016.
- For medical non-elective patients, the average length of stay was 7.2 days, which is higher than England average of 6.7 days.
- Data supplied by the trust showed that for admissions between 1 March 2016 and 31 March 2017 showed patients experiencing one ward move equated to 43.1%, two to five ward moves 16.4% and patients experiencing six or more ward moves 0.7%. 39.8% of patients did not experience a ward move during their admission. This included clinically necessary transfers.

However:

- Between November 2015 and October 2016, the average length of stay for medical elective patients at the trust was 2.9 days, which is lower than England average of 4.1 days.
- We saw significant improvements in the AMUM and AMUL performance due to changes in the physical environment.
- Patients living with dementia and those who had suffered stroke had "This is me." documentation in place. The division had dementia strategy and delirium strategy in place and supported by a dedicated dementia team.
- If patients had complex needs or required additional family support, staff made special arrangements regarding visiting and access to patients outside of normal visiting hours.
- The trust had significantly invested in the recruitment of discharge co-coordinators who worked across the wards to promote the safe and timely discharge of patients.

# Medical care (including older people's care)

- All staff we spoke with knew how to report a complaint and that feedback from complaints would be shared on a one-to-one basis where necessary or via team meetings.
- The following specialties were above the England average for admitted RTT (percentage within 18 weeks), neurology, geriatric medicine and rheumatology.

## Service planning and delivery to meet the needs of local people

- We saw significant improvements in the AMUM and AMUL performance due to changes in the physical environment. At our previous inspection in November 2015, we routinely saw patients waiting in corridors and at the reception area for up to two hours. The new environment enabled the staff to stream patients much more efficiently, we saw waiting areas well managed, and patients no longer queued in corridors.

## Access and flow

- Between November 2015 and October 2016, the average length of stay for medical elective patients at the trust was 2.9 days, which is lower than England average of 4.1 days. Of the three top non-elective specialities, geriatric medicine and cardiology's average lengths of stay were lower than their respective England averages.
- For medical non-elective patients, the average length of stay was 7.2 days, which is higher than England average of 6.7 days. Of the three top specialities non-elective geriatric medicine and cardiology's average length of stay were lower than the England average.
- In January 2017, the trust's referral to treatment time (RTT) for admitted pathways for medicine showed that 81.9% of patients were treated within 18 weeks, compared to the England average of 89.1%. Between February 2016 and January 2017, the trust's performance was in-line with the England average until October 2016, where it fell below the average.
- The following specialties were above the England average for admitted RTT (percentage within 18 weeks), neurology, geriatric medicine, rheumatology, and dermatology.
- The following specialties were below the England average for admitted RTT (percentage within 18 weeks), gastroenterology, thoracic medicine, and cardiology.
- At the time of our inspection, wards were 100% occupied. The trust had introduced a ten-by-ten system that aimed to see the medicine division have ten beds discharged by ten o'clock every day. Staff we spoke with agreed that in principle, the system was a good idea. However, it was not always possible to achieve. Staff said they often felt under pressure from site managers to discharge or take patients when due to issues in relation to community spaces or simply getting a patient to their own home, made discharge difficult.
- The trust had significantly invested in the recruitment of discharge co-coordinators who worked across the wards to promote the safe and timely discharge of patients. The coordinators worked with the ward staff, multidisciplinary team, and external agencies, for example community care and families to improve discharge outcomes.
- Data supplied by the trust showed that for admissions between 1 March 2016 and 31 March 2017, 39.8% of patients did not experience a ward move during their admission. Patients experiencing one ward move equated to 43.1%, two to five ward moves 16.4% and patients experiencing six or more ward moves 0.7%. This included clinically necessary transfers.
- The issue of elderly patients experiencing ward moves was on the medicines risk register and the trust had established systems to mitigate the risks including; consultants attending handovers and the senior nurse from older people's medicine to oversee patient flow amongst others.
- The average length of emergency patient stay on the AMUM before discharge between March 2016 and March 2017, ranged between 0.9 and 0.6 calendar days. The average length of stay on the AMUL during the same period ranged between 0.9 and 0.7 calendar days.
- The AMUM had only one elective patient between March 2016 and March 2017, who stayed on the ward in October 2016 for three days before discharge. The AMUL had three elective patients, one in June 2016, who did not stay, and one in both August and December 2016. Both stayed one day before discharge.
- On reviewing patient records, we noted a date stamp relating to the anticipated discharge date for the individual patient. Staff said that they did not always achieve these dates but they gave a clear direction of travel towards the patients discharge.
- We spoke with two discharge coordinators; both said that there remained challenges in discharging patients due to the constraints of community care and

# Medical care (including older people's care)

repatriating patient's home. All staff we spoke with on the wards valued the support of the discharge coordinators and felt the role had made a positive impact on the patient discharge process.

- Data supplied by the trust showed that between January 2017 and March 2017, the medical wards routinely held outliers that were not specialty medical patients. In January 2017, there were 176 outliers, this reduced to 131 in February 2017 and to 155 in March 2017. Staff readily identified outliers and medical staff saw patients in a timely and appropriate fashion. The stroke service had a dedicated consultant who specifically looked after outliers.
- Data supplied by the trust showed that between March 2016 and March 2017, 293 patients were in hospital longer than 60 days or more before their discharge.
- The number of patients admitted via the emergency care department to the AMUM between March 2016 and March 2017 was 8,149. In the same period, the number of patients admitted via the emergency care department to the AMUL was 8,983.
- Data supplied by the trust showed the average patient waiting time for an endoscopy procedure between March 2016 and March 2017 was 19.9 days.

## Meeting people's individual needs

- Patients living with dementia and those who had suffered stroke had "This is me" documentation in place. The division had dementia strategy and delirium strategy in place and supported by a dedicated dementia team.
- Staff identified patients living with dementia by a forget-me-not symbol displayed outside of their room and where appropriate on patient records. Staff also used a wristband for some patients to promote staff awareness that the patient was living with dementia.
- A dementia support team assisted ward staff with expertise in how to care for patients living with dementia.
- Dementia support workers were actively engaged in activities with patients during our inspection. Patients played bingo, listened to music, and made Easter baskets to support fundraising. The staff utilised a large touch screen tablet that could be used as a record player, a bingo screen or simply to show old photos and pictures to aid patient memory and recollection.
- Speech and language therapy (SaLT) saw patients who had had a stroke promptly to reduce the time patients

spent nil by mouth. Records reviewed showed a prompt review by SaLT, and staff we spoke with spoke highly of the specialist support offered specifically in relation to swallowing and dysphasia support.

- We observed occupational and physiotherapists working closely with the nursing and medical teams to promote patient welfare and condition management. Therapists promoted individual needs and the use of specialist equipment to promote mobility and activities of day-to-day living to promote patient independence.
- The staff had access to a learning disability trained nurse who could offer individual guidance in relation to the promotion of communication and how to meet the needs of patients admitted with a learning disability. In some clinical areas, relatives were able to stay with patients.
- If patients had complex needs or required additional family support, staff made special arrangements regarding visiting and access to patients outside of normal visiting hours.
- Staff had prompt access to specialist equipment including bariatric and pressure relieving equipment.
- Staff had access to translation services for patients whose first language was not English.

## Learning from complaints and concerns

- All staff we spoke with knew how to report a complaint and that feedback from complaints would be shared on a one-to-one basis where necessary or via team meetings.
- The medicine division received 438 complaints between January 2016 and January 2017. Complaints covered a wide range of subjects from clinical care, waiting times and quality of care amongst others and we found the trust response rates to complaints was in line with the complaints policy.
- Staff notice boards displayed learning from complaints and actions taken by the trust to minimise complaints in the future.

## Are medical care services well-led?

Requires improvement 

We rated well-led as requires improvement because:

# Medical care (including older people's care)

- The majority of staff we spoke with on the wards were unaware of any local vision or strategy held by the trust in relation to the medical division.
- Some staff felt there was unnecessary pressure placed on them to take and discharge patients from the wards and that at times and they did not have the skills or support to effectively care for those patients.
- There were poor results on staff engagement in the 2016 NHS staff survey. However, there was a plan in place to address these.
- The majority of staff we spoke with said that the executive team were not visible in ward areas. Some staff said they saw them infrequently at bed meetings, but most agreed that the senior team members were not visible.

However:

- There were established systems to ensure good clinical governance and monitor performance.
- Senior leadership within the division had a clear strategy of how they division would progress to meet increasing demands on services.
- Action had been taken to improve pathways such as through the ambulatory care service.
- The majority of staff we spoke with felt supported and valued by their direct line manager.
- Junior nurses we spoke with told us that the medical division was a good place to start their career.
- Leadership of the division were sighted on the poor staff survey results and had completed an action plan to address these. There was improved leadership in the division who had a clear strategy moving forward.

## Leadership of service

- The division was led by a triumvirate of Chief of Division, Divisional Nurse Director and Divisional Operations Director.
- The majority of staff we spoke with felt supported and valued by their direct line manager. However, some staff told us that they felt there was a lack of senior leadership within the medical division.
- Some staff felt there was unnecessary pressure placed on them to take and discharge patients from the wards and that at times and they did not have the skills or support to effectively care for those patients. Some said that staff who did not understand the impact of their decisions on the wider teams or the patients themselves often made decisions in relation to capacity and flow.

- The majority of staff we spoke with said that the executive team were not visible in ward areas. Some staff said they saw them infrequently at bed meetings, but most agreed that the senior team members were not visible.
- Local leaders were highly respected by staff we spoke with and staff felt respected and engaged with the services.
- All the senior members of nursing staff we spoke with had a good understanding of the current staffing levels, staff vacancies and staff sickness levels and taking appropriate action to provide cover where necessary.
- Medical staff we spoke with raised concerns regarding the management of annual leave and stated that the busy rota prevented doctors from taking annual leave.

## Vision and strategy for this service

- Senior division leadership had a clear strategy for the development of the services and need to manage capacity and different ways of working. For example, development of the ambulatory care service and pathway had led to a reduction in admissions.
- The majority of staff we spoke with on the wards were unaware of any local vision or strategy held by the trust in relation to the medical division. However, we did note the Norfolk and Norwich University Hospitals five-year strategy displayed on some of the wards we visited.
- Staff we spoke with knew the values of the trust and we saw these displayed throughout the wards we visited.

## Governance, risk management and quality measurement

- There were several established systems to ensure good clinical governance and monitor performance.
- Senior leaders in the service had good oversight of the risks and opportunities of the service. They were able to identify concerns on the risk register and what steps they were taking to address these. The risks included staffing and capacity amongst others.
- Clinical governance meeting happened fortnightly with key staff. Meetings included a broad mix of nursing, medical, and multidisciplinary staff amongst others and details of the meeting and minutes circulated to staff. Each meeting produced action points as required. We saw that these shared with the teams in flexible ways, by email and daily briefing meetings to ensure continual improvement to quality of the service.

# Medical care (including older people's care)

- The medicine division risks were included on an electronic system which identified risks to the service. The risk register included a 'RAG rating' of the level of risk, controls put in place to manage the risk and timelines for review. The risks identified included:
- Assessments of the risks associated with caring for general older people's medicine patients with a history of falls.
- Misuse of cardiology elective beds.
- Lack of formal arrangements for covering consultants leave.
- Pressure care on older people's medicine wards.
- Not all medical and nursing staff we spoke with during our inspection knew the medicine division held a risk register or the associated risks. However, senior staff monitored the risks identified and took appropriate action to mitigate any impact on patients and staff.
- The medicine departments did participate in a number of audits to measure the quality of provision, these included local audits, for example hand hygiene, record keeping, medication, and care planning.
- The medicine departments also participated in national audits for example, the Sentinel Stroke National Audit Programme (SSNAP). The trust's SSNAP performance has remained consistent since the last audit for April to July 2016, with eight domains scoring B or higher for both patient-centred and team-centred. The only two domains to score lower were 'domain 2 stroke unit' and 'domain 7 speech and language therapy', scoring C for both patient-centred and team-centred care.

## Culture within the service

- Junior nurses we spoke with told us that the medical division was a good place to start their career. Managers gave them clear leadership and feedback on their performance on a regular basis and made them feel valued as part of the team.
- All staff we spoke with told us they felt the medicine division was a supportive and interesting place to work. We saw staff interacted in a supportive way within the department to ensure safety and efficiency for patient care and that there was a positive and calm feeling within the team, even during very busy periods.
- We found a strong culture of multidisciplinary staff working on the wards we visited. Therapy staff felt included by nursing and medical staff in decisions

related to patient care and treatment. We observed staff working closely, recording guidance in patient notes and positive communication to meet the needs of patients and staff on the wards.

## Public engagement

- Staff on Hethel ward told us they supported a 'breathe easy group' on a monthly basis, in order provide patients with ongoing advice in relation to their treatment and care needs. The breathe easy group gave opportunities for patients with respiratory needs and their respective family members to meet and share experiences.
- Wards specifically catering for patients living with dementia encouraged volunteers and visitors to engage with the service in a number of ways. We saw examples of music groups and a choir who would support events and engage patients in activities to promote their social and emotional wellbeing.

## Staff engagement

- Staff we spoke with told us they attended regular team meetings with their managers and received information in a number of ways; face-to-face, email, and newsletters.
- Staff said that the senior leadership team held open forums, but felt these were at the wrong times due to work commitments or they were unable to attend due to their workload.
- The 2016 NHS staff survey had shown poor performance, particularly in staff engaging. This included the trust performing in the lowest 20% of trusts for staff engagement including staff motivation and ability to contribute to service developments.
- Scores in the lowest 20% of trusts were also for staff reporting good communication with senior managers, staff satisfaction with their ability to deliver good care and quality of non mandatory training and development.
- The trust scored in the top 20% of trusts for flexible working, equal opportunities, low levels of staff reported stress and percentage of staff working extra hours.

## Innovation, improvement and sustainability

- We saw significant improvements in the AMUM and AMUL performance due to changes in the physical environment. At our previous inspection in November 2015, we routinely saw patients waiting in corridors and

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

at the reception area for up to two hours. The new environment enabled the staff to stream patients much more efficiently, we saw waiting areas well managed, and patients no longer queued in corridors.

# Surgery

Safe	Requires improvement	●
Responsive	Requires improvement	●
Well-led	Requires improvement	●
Overall		

## Information about the service

Norfolk and Norwich University Hospital NHS Foundation Trust provides a range of surgical services including general surgery, elective and trauma orthopaedics, ear, nose and throat (ENT), urology and vascular. The trust had 48,123 surgical admissions between November 2015 and October 2016. Day admissions accounted for 23,553 (49%), 15,666 (33%) were elective, and the remaining 8,904 (19%) were emergency. Surgery for children is covered in the children and young people section of the report.

The service has eight surgical wards at the trust comprising, 292 inpatient beds, 26 day-case beds and 28 operating theatres. The service also has a surgical assessment unit. We inspected six wards, the surgical assessment unit, the day surgical ward, the recovery area and a sample of the theatres undertaking both inpatient and day case surgery. Due to ward refurbishment, care normally provided on Gissing ward was on Coltishall ward and Edgefield ward was on Gissing ward.

During this inspection, we spoke with 44 staff, including doctors, nursing, therapies and housekeeping staff, nine patients and three relatives. We reviewed 11 sets of medical records and 11 nursing assessments and plans of care records, along with a variety of information provided by the trust.

## Summary of findings

- The trust reported four never events between February 2016 and January 2017.
- There were no local observational audits or measurement of the quality of the World Health Organisation (WHO) five steps to safer surgery checklists.
- Staff did not follow infection prevention and control procedures. Staff on Gissing and Earsham ward, left side room doors open when they should have been closed to prevent the spread of infection.
- Medicine management and security was not robust.
- The storage and security of patient medical records was not robust.
- Nurse staffing did not reflect the acuity of patients on some of the surgical wards. There was a high number of nursing vacancies and gaps in working rotas were frequently filled with healthcare assistant hours. We were concerned that staffing shortfalls could impact on patient care.
- Resuscitation equipment on the wards and was not adequately checked and maintained.
- Staff compliance with some aspects of mandatory training such as safeguarding were well below trust target.
- Patients were frequently delayed in theatre and the number of bays available in recovery was not in line with guidance from the Department of Health. Health building note (HBN) 26 Facilities for Surgical Procedures states there should be two recovery bays for every theatre. We saw there were 16 adult bays for 17 theatres.
- The trust had cancelled 2,647 procedures between quarter 4 2014/ 15 and quarter 3 2016/ 17, 20% of these patients were not treated within 28 days.

# Surgery

- Staff morale was low within the surgery division with staffing and clinical pressures contributing factors. A shortage of medical beds throughout the hospital meant that ward staff felt pressurised to take patients who were not suitable for their ward areas and there was a lack of communication between the ward and the board.

However:

- Staff reported incidents and were knowledgeable about the incident reporting process.
- The trust had clear processes and procedures in place for safeguarding.
- Ward areas were visibly clean, with appropriate equipment and facilities for hygiene and infection control. Staff accessed equipment such as hoists and scales that were serviced and checked in line with policy.
- Staff completed patient care records legibly and signed and dated entries.
- There had been an improvement in referral to treatment times in the division since the beginning of 2017.
- One stop clinics were available for hand and cystoscopy surgery patients and the day patient unit (DPU) was proactive in reducing patient admissions.
- Translation services were available and patient information leaflets were available in different languages and formats.
- There was evidence of learning from complaints in the form of “you said we did” posters.
- Staff we spoke with knew the vision and values of the trust and junior staff felt supported by their ward managers. Most ward staff felt they had a good team.
- Ward managers and surgical matrons attended monthly surgical governance meetings. There was evidence that the ward team discussed their performance around the quality indicators used at the trust.
- The trust had a plan to develop, refurbish and expand the high dependency unit and develop level two beds on Gissing ward. Staff we spoke with knew about the plan and how it would impact them.

## Are surgery services safe?

Requires improvement



We rated safe as requires improvement because:

- The trust reported four never events between February 2016 and January 2017.
- There were no local observational audits or measurement of the quality of the World Health Organisation (WHO) five steps to safer surgery checklists.
- Staff did not follow infection prevention and control procedures. Staff left side room doors open when they should have been kept closed to minimise the spread of infection.
- Staff compliance with some of aspects of mandatory training, for example safeguarding was well below trust target.
- Staff management and security of medicine was not robust.
- Staff storage and security of patient medical records was not robust.
- Nurse staffing did not reflect the acuity of patients on the ward. There was a high number of nursing vacancies and gaps in working rotas were frequently filled with healthcare assistant hours. We were concerned that staffing shortfalls could impact on patient care.
- Staff did not adequately check and maintain resuscitation equipment in the wards and theatres we visited.

However:

- Staff reported incidents and were knowledgeable about the process of incident investigation.
- Ward areas were visibly clean, with appropriate equipment and facilities for hygiene and infection control.
- Staff accessed equipment which had been serviced and checked in line with trust policy.
- We reviewed 11 patient records both nursing and medical and found the majority of them well completed, clearly legible and signed and dated by staff.
- The trust had clear processes and procedures in place for safeguarding adults and children.

## Incidents

# Surgery

- The trust had a system and process for reporting incidents. Staff understood the process and this was confirmed verbally, both at junior and senior level. The incident reporting form was accessible via an electronic online system. Staff received feedback on incidents from the matron and at ward meetings.
- The trust reported 26 serious incidents between February 2016 and January 2017. The most common of these were: pressure ulcers, ten in total (39%), six related to slips, trips or falls (23%) and six surgical invasive procedures (23%).
- The trust changed procedures around the checking and administration of intravenous (IV) drugs following an investigation into a previous incident. This demonstrated learning from incidents taking place.
- Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- The trust reported four surgical incidents classified, as never events, between February 2016 and January 2017. Two of the four involved wrong site surgery, one involved Orthopaedic surgery where the wrong-sided implant was inserted and one related to inadequate tumour resection resulting in a second surgical procedure being necessary. All four never events were fully investigated, with actions identified to reduce the risk of reoccurrence. In relation to the never event with the incorrect implant a new process was put in place where implant specifics are now displayed on a white board during surgery to allow the theatre team, including surgeon, to reference throughout the procedure.
- Staff we spoke with, in both main theatres and day surgery unit (DPU) were aware of the never events. There had been communication to the team, support provided to the staff involved and a full team forum for learning event had taken place. Incidents, identified actions and learning were also included in a published newsletter, which was seen displayed in both main theatres and DPU. In addition the division had introduced 'The trust held staff "safety huddle" meetings, on a fortnightly basis, for any staff to attend and share concerns and discuss learning from incidents and investigations.
- Mortality and morbidity was covered as a standing agenda item at the monthly governance meeting. Medical staff reviewed recent patient deaths to identify any concerns and identify potential learning to improve patient safety.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Three nursing staff we spoke with stated that they knew the duty of candour regulation meant that they had to be honest and open about any untoward serious incidents that occurred. Data provided demonstrated that duty of candour had been undertaken following the never event incidents.

## Safety thermometer

- The trust monitored the incidence of falls, pressure ulcers and catheter urinary tract infections. The patient safety thermometer showed that the trust reported 24 new pressure ulcers, two falls with harm, and three new catheter urinary tract infections between February 2016 and February 2017. Information we saw on ward safety dashboards was in line with these figures.
- The trust quality and safety dashboard data was visible in each ward area. Safety crosses were on notice boards throughout the surgery wards and displayed results for patient falls and pressure ulcers (PU). Safety crosses were updated monthly by ward managers. Earsham ward safety cross showed two avoidable pressure ulcers, one in December 2016 and another in February 2017. Gateley ward safety cross showed one avoidable pressure ulcer in November 2016. On Gateley ward we saw the trust had introduced "repositioning clocks" above patient beds so nursing staff could clearly identify which patients needed turning and when to reduce the number of new pressure ulcers.
- The ward manager held performance meetings with the divisional lead nurse or associate director of nursing to discuss the quality and safety dashboard. Staff told us "It feels like a fruitless exercise as the issues raised are always the same, mandatory training for example, but there is no time to do anything about them due to staffing issues".
- The National Institute for Health and Care Excellence (NICE, 2010) recommends that all patients should be assessed for risk of developing blood clots on a regular

# Surgery

basis, and on admission to hospital. The trust audits the completion of the assessment for venous thromboembolism (VTE). Compliance with thrombosis risk assessment completion was 98% in November 2016, December 2016, and January 2017. This was an improvement from 95% in January 2016.

## Cleanliness, infection control and hygiene

- Staff had access to adequate hand washing facilities and alcohol gel dispensers were available throughout wards and corridors. Staff washed their hands and were “bare below elbows.”
- Personal protective equipment, gloves, and disposable aprons were available on ward areas and staff used them appropriately.
- Nursing staff wiped equipment down using antibacterial wipes between patient contacts and attached “I am clean” labels so other staff knew which equipment was clean.
- The trust used linen curtains in bathrooms and throughout surgical areas. However, curtains had no cleaning date displayed. We asked nursing staff about this and they explained the curtains were washed when they were dirty or changed monthly.
- Surgical hand hygiene audits between November 2016 and March 2017 showed, not all the surgical wards met the trust target of 98% compliance. Compliance was as low as 78% on Denton and Gateley in November 2016 and January 2017 respectively. Hand hygiene audits for the same period in main theatres met the trust target (98%) for compliance. Mandatory training compliance for infection prevention and control was 84% for nursing staff and but only 66% for medical staff, this was below trust target of 90%.
- On Gissing and Earsham ward, three side room doors had the sign “Enteric precautions. Please keep door closed” but staff left the doors wide open in each instance. Patients and staff were entering and leaving the rooms freely. This was not in line with the trust policy and increased the risk of the spread of infection. We raised this with a member of staff who told the nurses attending to the patient to close the door.
- There were daily and monthly cleaning records displayed in theatres within DPU. These were not consistently completed. The monthly record had five sections- preparation room, theatre, anaesthetic room, scrub and sluice. The record we reviewed had not been completed for January and February 2017. However the scrub section was complete for March 2017. The daily check had been completed on Monday but not Tuesday or Wednesday.
- We reviewed the ward dashboard for Gissing ward and Earsham ward and cleaning audit compliance (February 2017) was above trust target of 95%.
- Staff did not keep dirty utility areas locked in four of the wards. In Docking and Gissing, there were bottles of diluted cleaning solution left on the side. On Gissing ward, the bottles did not have lids on. This meant there was a potential risk to patients or visitors on the ward.
- There was appropriate waste segregation throughout wards and theatres. However, in theatres, there was no individual labelling of waste bags to identify case number or specific theatre. This meant that waste could not be identified for a specific case should the need arise, for example should an item of equipment or instrumentation go missing and the rubbish needed to be checked. We raised this with senior staff for consideration.
- During the last inspection, in November 2015, there was no robust process or oversight of the decontamination processing of flexible endoscopes within the operating theatres and the trust was required to take action. During this inspection we found that a vacuum pack system had been introduced that provided 30 days sterility. Flexible endoscopes were processed in the central sterile services department (CSSD) and were properly cleaned and decontaminated in line with national guidance.
- There was a clear pathway for clean and contaminated flexible endoscopes. Custom designed trollies were in place to transport endoscopes between theatres and CSSD. The trollies ensured clean (processed), used (contaminated) endoscopes were kept separate, and a colour coded cover on each tray (red / green) identified which were clean and which were used.
- Flexible cystoscopes were decontaminated in the DPU with a three-part Tristel system, which included a pre-clean, sporicidal treatment and rinse procedure in line with national guidance. Audit paperwork was completed to allow traceability.

## Environment and equipment

- Most wards had between 37 and 39 patient beds, in single sex bays arranged around a central facilities hub containing a kitchenette, sluice, clean utility and dirty

# Surgery

utility area. A nursing desk was on either side of the ward so that staff could see patients from each of the stations while writing in patients notes. Access to wards was via double doors secured with a card reader.

- We reviewed resuscitation equipment in five of the wards we visited. We saw records on Gissing Ward for March 2017 (temporarily being housed on Coltishall Ward) had gaps where staff had not completed equipment checks daily in line with trust policy. On Docking ward, staff had not checked resuscitation equipment on four of the previous nine days. We reviewed five random items per trolley, items were in date and stored correctly.
- All the equipment we checked, such as hoists, infusion pumps, weighing seats and blood pressure monitors were all tested and serviced in line with manufactures guidance and electrical testing requirements in all the wards we visited.
- Records demonstrated daily checks of adult and paediatric resuscitation equipment occurred in main theatres, recovery and DPU.
- A process was in place for daily checking of the difficult intubation trolley within main theatres, and records demonstrated that this was completed. However, during the inspection, we found that the sterility date of the fibre optic laryngoscope, which is used in the event of a difficult intubation, had expired three days earlier yet the records had still been completed and recorded as correct. We brought this to the attention of theatre staff and it was changed immediately. The department had disposable, single use, flexible fibre optic laryngoscope available for immediate use which meant that there was no risk to patient safety however; it did indicate that not all daily checks of this equipment were thorough.
- In theatres, equipment checking and servicing records were inconsistent. We reviewed a range of items, including stack systems, headlamps, dental drills, infusion pumps and specific operating equipment such as diathermy. Six of the nine items checked were in date for servicing.. One surgical stack system was out of date from May 2016 and another from April 2014. We raised this with the theatre manager, who confirmed that equipment maintenance was an area that needed to improve.

## Medicines

- We reviewed seven drug trolleys. We found staff had left two trolleys not secured to the wall with their tether. In

two trolleys on Earsham ward we saw loose blister packs. On Gissing ward one wall tether was broken meaning the trolley could not be secured to the wall and on Edgefield ward one drug trolley door was closed with micro-pore tape.

- Controlled drug (CD) cupboards were locked inside a locked cupboard in the clean utility room. Two nurses had to be present when opening the CD cupboard. We saw this in practice when reviewing the CD record book. Nursing staff updated the book on a weekly basis to record volumes and amounts of drug in storage. There were no omissions in the records we reviewed.
- Controlled drugs (CD) were managed appropriately in theatres. We reviewed CD registers in both main theatre and DPU. Registers were accurate, detailed the amount supplied, administered and discarded, were signed and dated and correlated with the stock.
- We reviewed the records for fridge and ambient room temperature monitoring where medications are stored in three wards and in theatres. Temperature monitoring by staff was inconsistent and there were frequently gaps where fridge and room temperatures had not been recorded, despite this being raised at the previous inspection in November 2015. This meant that any medicines stored might be adversely affected by being at the wrong temperature and therefore be unfit for use. Between January and March 2017 theatre staff recorded the temperature in theatre two on 26 days. Theatre staff recorded the fridge temperature on only nine days in March.
- The fluid store in main theatres was not secure. There was a key control access pad on the door however this was faulty and the door could be opened freely. We raised this immediately with the theatre manager to action and request repair.
- A pharmacist and a nurse prescriber were available in the pre-op assessment unit. This meant patients could receive medications in a timely way.

## Records

- The trust kept patient's medical records in unsecured trolleys, often with lids open, in all the wards we visited and trolleys were not always in the line of site of staff. This meant patient medical records were easily accessible to staff but would also be available to members of the public as they were not locked or secured.

# Surgery

- In the Surgical Assessment Unit (SAU) staff left patient notes out overnight in baskets in the corridor. The corridor was accessed by swipe entry system and anyone with a swipe card could access the unit. Staff told us this had been recognised as a problem but no changes had been made.
- We checked 11 patient medical records and found that they were legible and signed and dated by staff. Records included next of kin contact details, pre op assessments and consent forms.
- Staff who wrote in the patient medical records stuck in a specific coloured sticker so a patient review undertaken by their speciality could be easily identified. Occupational therapists and physiotherapists along with doctors and consultants had updated patient records.
- Staff kept nursing assessments and plans of care records at the bottom of individual patient beds. This meant that they were accessible to care all staff. We reviewed 11 records and noted they were well completed and accurate. Early warning scores, risk assessments for falls, pressure ulcers, and malnutrition universal screening tool assessment (MUST) were completed and staff signed and dated entries.
- At our last inspection we found that the surgical division staff failed to achieve mandatory training targets in a number of areas.
- Delivery of mandatory training was by a variety of methods including E-Learning and face-to-face sessions. Training included fire safety, basic life support, health and safety, infection control and information governance.
- The trust set an internal target of 90% completion for all staff groups for mandatory training. For surgical staff the overall training completion rate was 81%. Training completion rates for Ethnicity and Diversity was 89% Medicines Management was 86%, basic life support for adults was 75% and infection prevention and control was 84% for nursing staff and but only 66% for medical staff, this was below trust target.
- Some staff stated they experienced difficulty in being released to undertake face to face training due to staffing pressures on the ward. This was most notably on Earsham and Gateley ward. Between February 2016 and February 2017, Earsham ward hand hygiene training compliance was 82% against a target of 90%. On Gateley ward and Edgefield ward, resuscitation mandatory training compliance was 59% and 64% respectively against a trust target of 90%. However, nursing staff on Gissing ward were 100% compliant with safeguarding adults and infection prevention and control mandatory training.

## Safeguarding

- The trust had clear processes and procedures in place for safeguarding adults and children. Staff had E-Learning in safeguarding, dementia, and dignity training and were able to describe how to recognise a vulnerable person and what they would do.
- A safeguarding lead was available for advice and support. Staff gave examples of when they would refer patients to the safeguarding lead and the support they would receive.
- Surgery wide, safeguarding adult level two training compliance for nursing staff was 94.5%; this was above the trust target of 75%. Safeguarding children level two was 84.8% and level three was 90%.
- Safeguarding adult level two training compliance for medical staff was significantly lower than the trust target of 75% at 63.5%, safeguarding children level two was 59.7% and level three was 66.7%.
- Gateley ward safeguarding adults training compliance was consistently below trust target (75%) at 64%.

## Mandatory training

## Assessing and responding to patient risk

- The early warning score system (EWS) was in place across the surgical areas to identify any change in patient condition and ensure timely appropriate escalation for deteriorating patients. We saw EWS observations completed appropriately in all the records we reviewed.
- On Gateley ward we saw “repositioning clocks” above patient beds so nursing staff could clearly identify which patients needed turning and when to try to reduce the number of new pressure ulcers.
- Patients with dementia were allocated bed spaces near to the nursing desk so that they were more visible to staff.
- A number of patients were allocated bed spaces on surgical wards but should have been on medical wards during the inspection. These patients are called outliers. Nurses and medical staff assured us that the admitting

# Surgery

team reviewed boarders daily. However, two ward sisters told us that they frequently had to remind doctors where these patients were or that they had not been reviewed.

- Nursing staff told us that outliers on surgical wards caused patient care to be compromised. For example, non-surgical patients requiring one to one nursing who were placed on a surgical ward meant that one nurse or one health care assistant (HCA) was immediately occupied caring for the outlier patient leaving less staff to care for the other patients on the ward.
- Staff used the World Health Organisation (WHO) five steps to safer surgery checklist in all theatres. The WHO checklist is a core set of safety standards to improve patient safety. The five steps are briefing, sign in, time out, sign out and debrief which encompass all stages of the patient journey. Staff in both main theatres and DPU were observed completing steps two to four of the checklist appropriately. Staff stated that steps one and five, which are the briefing at the beginning and end of the theatre list, were undertaken however this was not formally recorded. This meant there was no opportunity to record issues, monitor and utilise as learning for improvement.
- Despite the occurrence of four never events there was no system established within main theatres or DPU to undertake observational audits as a measure of the quality and compliance with the WHO check. One finding from the never event involving wrong site surgery was that the theatre time out was not undertaken. Time out provides an additional opportunity for the surgeon to review imaging and confirm that the correct side for surgery has been identified on the consent form, marked and that the theatre list is correct.
- The lack of local audit or measurement to ensure the WHO five steps to safer surgery was effective was raised during our previous inspection in December 2015. We were provided with data that one observational audit had been undertaken. The audit encompassed 15 theatres, was not dated, and was brief in content and limited in data and outcomes. It asked four questions and the results were as follows:

Did the Checklist have full team engagement? 73%

Was the checklist audible? 100%

Were all team members present in the room? 73%

Were any variations recorded? 27%

Actions identified were to add the quality of WHO checklist completion to the Trust Annual Audit Programme for 2017-18 and to review the team brief and de-brief sections of the five steps to safer surgery and implement. There was no individual identified to lead these actions and no date for follow up. We were concerned that quality checks had not been implemented.

- Staff in theatre completed instrumentation checks against tray checklists however; the check was not recorded correctly on the checklist. This meant that should there be a query regarding a missing instrument there was no way of tracking at what point this occurred. We raised this as a concern to the senior staff in main theatres and DPU.
- There was an established process for pre-operative assessments with a clear day surgery assessment criteria. There was anaesthetists cover available within pre-assessment to enable an immediate anaesthetic review of patients with more complex medical history or concerns.

## Nursing staffing

- The service uses the Safer Nursing Care Tool to determine the numbers of registered nurses on duty. Numbers of nurses could be increased to reflect clinical judgement and patient acuity. However, in general, the surgical staffing was five registered nurses and three healthcare assistants during the day and three registered nurses and two care assistants during the night.
- Nurse staffing numbers, both planned and actual, were clearly displayed at the entrance to wards. We checked on a number of wards to ensure the numbers displayed were accurate and saw they were.
- The trust employed Advanced Nurse Practitioners (ANP) on Denton, Earsham and Gateley to take over patient care postoperatively. Staff told us they felt this was working well and was pushing the boundaries of nursing practice.
- The Gissing ward August 2016 team safety huddle meeting minutes recorded "Nurses feel stressed at night when only two nurses are on shift. Don't get breaks or meals." The action was marked as closed "things have improved". On Gissing ward during February 2017, 61% of shifts were unfilled, 48% were unfilled on Gateley and 21% unfilled on Earsham.

# Surgery

- There was ongoing nurse recruitment across the surgical areas. All the wards we visited were below establishment for nursing. Earsham and Denton both had nursing vacancy rates of 19% and on Docking ward the vacancy rate was 13%. On Gissing ward and Edgefield ward the nursing vacancy rate was 10% and 7% respectively.
- Where shifts were unfilled agency and bank staff were utilised to bridge gaps. Data supplied by the trust showed that from May 2016 to October 2016 agency staff usage ranged from five to 25%. The highest agency staff use was on Earsham ward and the lowest on Dilham ward. Denton ward used three bank staff and three agency staff for one of the days during our inspection. Data was not provided specifically for theatres but senior staff stated that there were approximately six agency staff used regularly within the Orthopaedic theatres. There were no formal records or assurance provided that these staff had received an induction to theatres when they started in the department.
- Theatre staffing was below establishment in main theatres, recovery and DPU. There was increased use of agency staff in main theatres. The introduction of recovery critical care area from October 2016 had resulted in staffing pressures. Initially there was an agreed staffing arrangement with 50% from the intensive care unit (ITU) and 50% recovery; however this was unsustainable. At the time of inspection the area was fully staffed by ITU. The majority of patients in this critical care area were level two; however there had been two level three patients in the recovery area overnight two weeks prior to our inspection but staff stated that this was an exception. There had been a high turnover of staff in recovery leading to four vacancies at the time of inspection.
- In theatre only one member of substantive staff was trained in advanced life support (ALS) as the training had been discontinued for nursing staff. Following staff raising concerns this had been re-introduced and place were booked for appropriate staff to attend in June and July 2017. A new staff recovery skills and competency pack had also been introduced.
- The additional Vanguard operating theatre was staffed with operating department practitioners and theatre nurses provided by Vanguard. However the ward area, consisting of an eight-trolley bay, was staffed by day surgery unit (DPU) staff. At the time of our inspection,

there were five whole time equivalent (WTE) registered nurse vacancies within the DPU. This deficit was covered by bank staff and overtime. Senior nursing and operating department practitioners also worked clinically resulting in no agency use within the DPU.

- The trust was actively recruiting to attempt to address the vacancies across surgery. Actions included a rolling two-week advert for theatre vacancies, a recently attended recruitment fayre where DPU had been a focus, and an open theatre recruitment day planned for May 2017.

## Surgical staffing

- In November 2016, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was the same.
- The trust used the Hospital at Night system to provide medical cover in the evenings and overnight. Staff told us this could be a slow process. At weekends, nurses could “bleep” junior doctors for medical input.
- Junior staff (First year 1/2) and middle grade doctors provided weekend ward cover, with cover available from a consultant on call. Weekend ward rounds occurred and twilight cover was available from an FY1/2 doctor.
- The use of locum cover in vascular surgery was relatively low at 3.5%. However, locum use in oral surgery was 86%, general surgery was 21.4% and plastic surgery was 13.1%.
- Medical Intensivists provided all medical cover for the recovery critical care.

## Major incident awareness and training

- There was a major incident plan and business continuity plan in place to deal with any incidents likely to disrupt or have significant impact on its services.

## Are surgery services responsive?

Requires improvement 

We rated responsive as requires improvement because:

- The trust was failing to meet the referral to treatment time (RTT) for all surgical specialities except for ophthalmology. ENT was at 43% against an England average of 66%. General surgery at 48% and trauma orthopaedics at 47%.

# Surgery

- The trust cancelled a high number of procedures. In 2016 there was an average of 2% of all surgeries cancelled short notice (compared to 0.9% nationally). Of these 20% were not treated within 28 days (this is against a national average of 9%).
- There were frequently delays in theatre and the number of recovery bays was not in line with guidance.

However:

- Stays for elective and non elective patients were better than the England average.
- One stop clinics were available for hand and cystoscopy surgery patients.
- The day patient unit (DPU) was proactive in helping to reduce inpatient stays and reduce the need to utilise DPU as an escalation area. Translation services were available and patient information leaflets were available in other language and formats.
- There was evidence of learning from complaints in the form of “you said we did” posters.

## Service planning and delivery to meet the needs of local people

- One stop services were available in the hand clinic and the cystoscopy clinic. This meant patients were seen, admitted, treated and discharged in one appointment. Minor hand surgery was performed in the Vanguard theatre and cystoscopy performed within a treatment room in the DPU.
- The DPU had extended opening hours until 10pm to increase capacity for day patient cases and reduce the number of patients being admitted.
- The day case theatre was open on Saturdays to elective cases to meet the needs of local people.
- The matrons undertook a daily and weekly review of patients who were due to come into hospital to ensure that a bed was available to meet their needs.

## Access and flow

- A number of patients were allocated bed spaces on surgical wards but should have been on medical wards during the inspection. These patients are called boarders. The number of medical boarders had been reduced from approximately 80 a day at our last inspection to around 40. On the day of inspection, the number of medical patients in surgical beds was 32. Nurses and medical staff assured us that the admitting team reviewed outliers daily. However, two ward sisters

told us that they frequently had to remind doctors where these patients were or that they had not been reviewed. We were concerned that the number of outliers compromised patient care.

- The service monitors the use of its theatres to ensure that they are responsive to the needs of patients. In January 2107 a total of 25 theatre slots across main theatres, day patient unit (DPU) and Vanguard were unused, this rose to 34 in February 2017.
- The trust’s theatre utilisation target was 80%. Between October 2016 and March 2017, DPU utilisation was 65%, ophthalmology 74%, Vanguard 67% and main theatre 76%.
- Between February 2016 and January 2017, the trust’s referral to treatment time (RTT) for admitted pathways for surgical services was consistently worse than the England average performance.
- However, there had been an improvement in referral to treatment times in early 2017 with 82% being completed within 18 weeks.
- Between November 2015 and October 2016, the average length of stay for surgical elective patients was 3.1 days, compared to 3.3 days for the England average. For surgical non-elective patients, the average length of stay was 4.2 days, compared to 5.1 for the England average. Elective General Surgery and Urology and non-elective General Surgery all had higher than average lengths of stay than the England average.
- The trust cancelled a high number of procedures. In 2016 there was an average of 2% of all surgeries cancelled short notice (compared to 0.9% nationally). Of these 20% were not treated within 28 days (this is against a national average of 9%).
- Nursing staff told us discharge planning started at admission. Some of the patients we asked about discharge plans were aware of their planned discharge date.
- In January there were 103 patients and February 104 patients readmitted to the hospital post-surgery. This increased to 117 patients in March 2017.
- The number of bays available in recovery was not in line with guidance from the Department of Health. Health building note (HBN) 26 Facilities for Surgical Procedures states there should be two recovery bays for every theatre. We saw there were 16 adult bays for 17 theatres. There were plans to mitigate this risk with the development of Gissing ward and the relocation of the recovery critical care by September 2017.

# Surgery

- The introduction of recovery critical care area from October 2016 had impacted on recovery capacity with the area utilising four bed spaces. This meant that there was a potential for patients to be delayed in theatre when the recovery area was full. Staff told us the day before our inspection four patients had been held in theatre because there was no space within recovery and there had been no beds available on wards. We requested utilisation data for patients held in theatre due to a delay into recovery, broken down into monthly figures but were informed that the trust was unable to provide these figures although there were plans to be able to do so in the future.
- Information provided by the trust showed, on average, 13% of operations performed in the DPU started late, 10% in Vanguard, 9% in ophthalmology and 8% in main theatres in January, February and March 2017.
- In theatres, the DPU manager was actively working with the bed manager on a daily basis to identify and convert appropriate overnight patients to day case patients, in order to increase inpatient capacity. Patients were asked to consent to becoming a day patient and advised that they may be being discharged home late in the evening. This in turn reduced the need for DPU to be utilised as an escalation area which was raised as a concern during the last inspection in November 2015. Data figures demonstrated a positive impact between September and December 2016. In September 2016 there had been two patients that had a ward stay in DPU overnight but none between October and December 2016. However there had been a decline between January and March 2017 with figures for overnight stay patients being 15, 17 and 25 respectively.

## Meeting people's individual needs

- The trust employed learning disability link nurses to provide support to patients and the nursing staff caring for them. Nursing staff invited patients with learning disabilities to come to the ward to familiarise themselves prior to their admission.
- We noted that there were leaflets available on a number of different procedures and conditions. These were available in different languages and larger print.
- Staff knew of the availability of translation services for people who did not speak English as a first language. This could be by telephone "language line" or face to face.

- We saw a patient who was living with dementia had extra care provided by their regular carer in addition to hospital staff. Staff told us this was common for patients with learning disabilities and dementia and meant there was continuity of care and provided reassurance to the patient.
- Patient toilets and bathrooms were large enough to accommodate wheelchairs.
- Signs on toilet doors throughout wards had pictures to help patients who were living with dementia and partially sighted patients.
- We noted that there were leaflets available on a number of different procedures and conditions. These were available in different languages and larger print.

## Learning from complaints and concerns

- Evidence of learning from complaints was available in the form of "You said we did" posters. Patients had said it was difficult to understand all the information given to them during ward rounds. The trust had introduced coordinators attending on ward rounds to encourage and support patients to ask questions.
- We saw patient information leaflets detailing how to contact the patient advice and liaison service with compliments or complaints.
- Staff told us they handled complaints at ward level and reported to the ward manager.
- Information supplied by the trust showed there were 417 complaints against the surgical division from January 2016 to January 2017. The majority of complaints were in the categories "appointments including delays and cancellations" and "communications".

## Are surgery services well-led?

Requires improvement 

We rated well-led as requires improvement because:

- Staff morale was low within the surgery division with staffing and clinical pressure a contributing factor.
- Pressure on bed capacity meant that ward staff felt pressurised to take patients who were not suitable for their ward areas.
- There was a lack of communication between the wards and the board.

# Surgery

However:

- The majority of staff we spoke with were aware of the vision and values of the trust.
- The matron and the ward manager attended monthly surgical governance meetings. There was evidence that the ward team discussed their performance against the quality indicators used at the trust.
- Junior staff felt supported by their ward managers and most ward staff felt that they had a good team. There was good divisional leadership who were sighted on their risks and with a strategy for the division.
- There was a plan to expand and refurbish the high dependency unit and develop level two beds on Gissing ward.

## Leadership of service

- The surgical division was led by the divisional director of surgery, divisional lead nurse and divisional operations lead. Surgical matrons reported to the senior matron who in turn reported to the divisional team.
- There was good divisional leadership who were sighted on their risks and with a strategy for the division.
- Junior staff felt supported by their ward managers. Most ward staff felt that they had a good local team and could raise issues of concern.
- We received mixed feedback from staff on the support from matrons. Three ward sisters felt their surgical matron was very supportive saying the senior matron and the surgical matron had been known to get “hands on” when needed. Other ward sisters felt “micromanaged” and not supported or valued by the surgical or senior matrons.
- All the staff we spoke with felt divisional leads and the director of nursing (DON) were “invisible” Staff felt that communication pathways above matron level were “difficult” and confusing.
- Staff told us about an incident involving a patient attacking a nurse. The nurse received good support locally from the ward manager and the matron but staff further up in the organisation were unaware of the incident.
- Some nursing staff reported feeling pressured by staff in the operations centre to take patients onto the ward when they believed they were not appropriate for their particular ward based on patient acuity.
- There had been some instability and inconsistency in the senior manager role in theatres with three different

managers having been in post in the last three years. The theatre manager had been in post since November 2016, but had worked at the Trust since 2004. They reported good support from the senior surgical matron and felt they had autonomy to tackle issues and make changes. They had introduced fortnightly one to one meetings with the senior theatre staff.

- The theatre manager recognised that there was inconsistency in the level of responsibility, accountability and ownership amongst the senior theatre leads and was in the process of reviewing this. For example one individual was responsible for managing the staffing rota across all of theatres. Work was ongoing at the time of inspection to develop and divide this responsibility to give ownership of staffing to each senior specialty lead. Another potential area for responsibility was oversight of equipment maintenance per specialty lead.

## Vision and strategy for this service

- Most staff knew of the trust vision to provide every patient with the care we want for those we love the most. Staff knew the values of the trust were PRIDE (people focused, respect, integrity, dedication and excellence). Staff felt that this was embedded throughout the division.

## Governance, risk management and quality measurement

- We reviewed the trust risk register for surgery and saw there was oversight of risks with control measures in place to mitigate and reduce them with regular reviews.
- There was no separate risk register for theatres. Senior theatre staff could articulate the areas they felt were the biggest risk which included sharps incidents, equipment issues and staffing vacancies.
- A theatre management group had recently been established which was attended by the service director, deputy divisional operational director, senior matron, theatre manager and matron DPU. There had been two meetings at the time of inspection. In addition a theatre governance meeting was in the process of being established and had just had terms of reference agreed but no meetings had yet taken place. The planned reporting structure was as follows senior theatre leads

# Surgery

meetings would report issues, concerns and risk to the theatre governance meeting that in turn reports into the theatre management group. This was in its infancy and need to be embedded.

- Surgical matrons and ward managers attended surgical governance meetings monthly. During this meeting, there was evidence that the ward team were held to account for the quality indicators used at the trust. The main concerns raised were about staffing levels on the ward areas.
- Surgical matrons attended twice-daily operational meetings to discuss capacity and bed availability.
- Surgical specialist lead nurses met monthly to discuss issues arising, for example outliers.
- Each ward manager held performance meetings with the divisional lead nurse or associate director of nursing to discuss the performance dashboard. Staff told us “It feels like a fruitless exercise as the issues raised are always the same, mandatory training for example, but there is no time to do anything about them due to staffing issues”.
- In theatres, there was limited evidence of an effective auditing process for areas identified of potential risk. For example observational audit of the World Health Organisation (WHO) five steps to safer surgery checklist had been undertaken once and actions had not been implemented and there was no effective oversight of equipment maintenance. There was no formal recording of induction for agency staff in theatre.
- Senior staff in recovery had been involved in quality assurance audits across the trust, participating in audit review on Kimberley ward. These staff expressed this as a positive and an opportunity to review other areas and contribute to improved practice.

## Culture within the service

- Numerous staff told us they felt pressured by the site team especially during evenings and weekends to accept patients onto the ward.
- Staff told us they would like to take more responsibility for their own ward. Ward managers told us they had no responsibility for setting their budgets, choosing the paint colour for their ward or shortlisting applicants to be employed on their ward.
- Ward managers told us staff morale was low. Staff felt most disheartened when speaking about the lack of staff and the pressures this caused on them. Most were able to relate how this had affected patient care and

how this made them feel. Some staff reported that this pressure meant that team meetings were frequently not held and that they felt that they were constantly requesting more staff.

- Theatre staff told us operating theatre lists routinely overrun and staff were reluctant to cancel operations for fear of being told “It will be your fault that patient doesn’t get their surgery and has waited all day” and “they (the patient) will get their op’ cancelled and it will be your fault”.
- Theatre staff we spoke to reported good team working, especially within individual specialties. The theatre housekeeping team felt included and stated they received communication via the intranet or staff communication book.

## Public engagement

- The trust had a number of volunteers who worked within the hospital. Part of their role was to assist patients to complete the friends and family test on discharge.

## Staff engagement

- The trust executives told us about “Speak up guardians” who were individuals who would “speak up” on behalf of staff who felt unable to raise concerns individually. None of the staff we spoke to were aware of them.
- The chief executive held trust wide staff meeting for all staff to attend. Some staff were aware of the chief executives meetings but few we spoke with had attended due to their workload.
- The DON held monthly meetings for band five and band two staff grades. Staff told us these were difficult to attend due to staffing pressures.
- The trust carried out an annual trust wide staff survey. Staff engagement trust wide for 2016 was 3.7 (range one to five where one indicates staff are poorly engaged and five indicates that staff are highly engaged). The trust's score of 3.7 was in the lowest (worst) 20% when compared with trusts of a similar type.
- Within theatres senior staff stated that there had been a decline in staff morale due to required changes in staff rotas and working hours. Staff in DPU had undergone a period of consultation to extend the opening hours and amend shifts accordingly. In main theatres some junior staff felt “muffled”. When we explored what this meant staff did not feel listened to. However we noted that work was ongoing to re-engage the senior theatre leads.

# Surgery

- There had been minimal engagement with the senior recovery staff regarding the implementation of recovery critical care area. There had been initial discussions but staff were only given 48 hours' notice of the start date. Following concerns raised by staff around additional patient acuity, a questionnaire had been sent to all recovery staff regarding training needs and identified plans were then put into place to facilitate additional identified training such as tracheostomy care and invasive monitoring. Arrangements were made for some recovery staff to work in ITU. Recovery staff stated that they felt that their concerns had been listened to and in response the decision was made to move the critical care area to Gissing ward.

## **Innovation, improvement and sustainability**

- There was a plan to expand and refurbish the high dependency unit (HDU) starting in September 2017. As part of this plan twelve beds on Gissing ward were identified for conversion to eight high dependency beds staffed by critical care staff. The plan was to train nurses in critical care during this period. Once HDU expansion and refurbishment was completed the eight beds would be kept as level two beds.

# Maternity and gynaecology

Safe	Requires improvement	
Effective	Requires improvement	
Caring	Good	
Responsive	Good	
Well-led	Good	
<b>Overall</b>	<b>Requires improvement</b>	

## Information about the service

Maternity and gynaecology services for Norfolk and Norwich University Hospitals NHS Foundation Trust

(N&NUHFT) were provided at Norwich University Hospital. Between April 2016 and February 2017, 5267 women gave birth to 5357 babies at the trust.

The trust employed 79 community midwives (CMW). They worked in nine teams across a wide geographical area, providing antenatal and postnatal midwifery care and a home birth service in partnership with general practitioners (GPs), health visitors and children's centres.

There were 65 maternity beds providing antenatal and postnatal inpatient care. Services available to women included home birth (by the CMWs), a consultant led 15 bedded delivery suite, a four bedded midwifery led birthing unit antenatal clinics, a foetal medicine clinic and a pregnancy wellbeing suite. Cley ward, which was shared with gynaecology, provided 14 antenatal beds for women. Postnatal inpatient care was provided on the 32 bedded Blakeney ward.

Gynaecology services encompassed 22 inpatient beds on Cley ward, an early pregnancy assessment unit (EPAU) and a gynaecology outpatient area which included hysteroscopy and cystoscopy procedures.

During the inspection we visited all the wards and departments relevant to both services.

We spoke with 17 midwives including six community midwives, three student midwives, eight nurses, nine medical staff, seven support workers, and seven

managerial or administrative staff. We also spoke with a pharmacist, sonographer, two operating department practitioners, six women at various stages of maternity care, four of those with their partners, and three gynaecology patients. We reviewed 14 sets of medical records and six prescription charts across both services, along with information requested by us and provided by the trust.

The previous inspection in November 2015 rated safe, effective, responsive and well led as required improvement, with caring rated as good. The main reasons for the required improvement ratings related to; insufficient staffing, delayed incident investigations, poor midwife to birth ratio, insecure medication storage, lack of IT for community midwives, poor appraisal rates, poor referral to treatment times in the gynaecology service, and lack of vision, succession planning and governance.

# Maternity and gynaecology

## Summary of findings

We rated this service as requires improvement because:

- Incidents were not always classified in line with trust policy
- Controlled medicines were not always checked and stored safely.
- Patient records were not stored securely and records audits indicated continued poor compliance in some areas.
- Resuscitation equipment was not always checked regularly in line with trust policy.
- Mandatory and safeguarding training were below the trust targets.
- Electronic discharge letters were not always sent within 24 hours meaning women's general practitioners were not informed of their hospital stay and outcome.
- Community midwives did not have access to information technology, although this was in the process of being addressed there was no time schedule yet.
- Patient outcomes were similar to the England average, but maternity dashboard outcomes such as the percentage of women breastfeeding at discharge, readmissions within 30 days and admissions to critical care unit consistently failed to meet targets.
- The gynaecology service did not meet its referral to treatment (RTTs) waiting times. There were 2543 patients on the gynaecology 18 week RTT incomplete waiting list and a backlog of 617 patients waiting up to 45 weeks for treatment.
- There was a lack of ownership at ward management level of issues such as checking resuscitation equipment, ward cleaning and medication checking.

However:

- There have been improvements in the investigation of incidents with staff given training and protected time to investigate.
- Midwifery staffing had improved since the previous inspection, and hospital midwifery staff were over establishment to accommodate leave.

- Staff provided care according to national guidance and evidence based practice and where they were not using guidance they risk assessed, reviewed and worked towards compliance.
- Staff contributed to a number of national audits and performed a range of local audits to improve women's care and shared results.
- Women we spoke with were very positive about their treatment by all clinical staff and the standard of care they had received.
- Women were involved in their choice of birth at booking and throughout the antenatal period. In antenatal clinics, women were given information regarding different birthing settings early on in their pregnancy, including the benefits and risks of home birth.
- Services were planned, delivered and co-ordinated to take account of women with complex needs, there was access to specialist support and expertise from medical and nursing and midwifery staff.
- There was strong leadership demonstrated from the senior management team, with a clear vision and strategy for the maternity service.
- The senior management had oversight of clinical risks and there was evidence that risks were regularly reviewed and updated with named ownership of risks.
- There was a strong drive to improve and develop with multiple innovations including the development of the IT system, and the Baby University scheme.

# Maternity and gynaecology

## Are maternity and gynaecology services safe?

Requires improvement



We rated safe as requires improvement because:

- Incidents were not always classified in line with trust policy.
- Controlled medicines were not always checked and stored safely and staff were not knowledgeable about frequency of checking.
- Patient records were not stored securely and records audits indicated continued poor compliance in some areas.
- Resuscitation equipment was not always checked regularly in line with trust policy.
- Mandatory training was below the trust target of 90% with compliance figures for medical staff at 60.4% and 72.3% for nursing and midwifery staff. Mental capacity act and deprivation of liberty training had not been undertaken during the past year for the staff we spoke.
- Maternity and gynaecology staff did not meet the trust target safeguarding training rates of 90% with medical staff not trained to level three children's safeguarding.
- World Health Organisation (WHO) Surgical Safety Checklist and five steps to safer surgery checklists were not consistently completed in full.
- Medical outliers on Cley gynaecology ward had a negative impact on staffing as their acuity was usually higher than the staffing allocation planned for.

However:

- Midwifery staffing had improved since the previous inspection, and were over establishment to accommodate leave.
- Staff were given protected time and training to investigate incidents.
- Facilities were all located in close proximity to each other which meant that the environment was appropriate in preventing delays in transferring women and babies to these areas.
- Wards and the delivery suite had locked doors and were accessed by staff keycard or by intercom to reception to keep women and babies safe.
- Clinical areas appeared clean and tidy and staff followed infection control procedures.

## Incidents

- The trust reported no never events, six serious incidents (SIs) in maternity and one in gynaecology between February 2016 and January 2017. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.
- We reviewed the root cause analysis (RCA) of the seven serious incidents and found robust investigation and lessons learned. There was evidence of change in practice such as the development of an information leaflet to explain the process during pregnancy for those women not entitled to NHS care, work around bladder care following pregnancy, changes to the telephone triage document to identify women who contact the delivery suite and midwife led birthing unit (MLBU) more than once, and recommendations for information technology in the community to enable midwives to use the electronic records interface.
- All staff who undertook incident investigation and reporting had received RCA training and felt confident using it and were given time away from clinical duties to investigate incidents. Three senior staff confirmed that they received support with incident investigation when requested.
- We reviewed a range of the 1,066 maternity and 162 gynaecology incidents reported on the trust electronic reporting system between April 2016 and March 2017. It was not clear from the evidence presented that the degree of harm was correctly recorded in line with trust policy. For example; fourteen patients had been retrospectively identified by the thromboprophylaxis team as having hospital associated venous thromboembolism (VTE) during admission or within 90 days. Of these, 11 were recorded as no harm, having been downgraded by the thromboprophylaxis team, two as moderate harm and one as low harm. Postpartum haemorrhages of more than 1,500 mls were reported as no harm. Other themes identified included 3rd and 4th degree tears during delivery, delayed

# Maternity and gynaecology

induction of labour (IOL) and delayed artificial rupture of membranes (ARM) due to lack of capacity on the delivery suite. The gynaecology incidents were varied but include themes such as falls and pressure ulcers. In instances where no harm had been reported it was not clear if delayed or missed treatment had required extra observation or minor treatment and causing minimal harm to patients.

- Senior staff explained that ‘the incidents were downgraded as the investigations had determined no harm had been caused by the trust as per trust policy’. We reviewed the trust Incident Reporting Policy and saw that the policy stated that ‘a patient safety incident was an event directly related to treatment or care of a patient which results in actual harm to the patient. This harm is not a normal consequence of care or treatment’. It also stated that ‘the severity of harm selected reflects the actual harm caused’, and that ‘this may have changed from that which was originally reported, as an outcome of the investigation’. We were not assured that incidents were always classified in line with trust policy although the appropriate RCA investigations did take place with learning shared with the teams.
- Staff described the incident reporting system and felt confident using it. They knew the outcomes of recent incident investigations and learning and we saw that these were included in team meetings, the staff risk update newsletter, displayed on staff noticeboards and the daily ‘safe hands’ meetings where staff discussed clinical care from the previous day.
- Staff told us about recent learning following concerns about women on the delivery suite developing pressure ulcers. Staff had undertaken tissue viability training in order to better assess this and learning had been shared.
- Monthly perinatal mortality and morbidity meetings were well attended by the multidisciplinary team (MDT) which included obstetricians, paediatricians, midwives, medical students and risk management leads. All serious cases were reviewed and minutes from meetings in January, February and March 2017 were seen and described changes in practice and lessons learned.
- Staff were knowledgeable about the requirements of duty of candour and we saw evidence of duty of candour applied in the incident reports that we reviewed. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify

patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

## Safety thermometer

- The NHS Safety Thermometer website states a safety thermometer “Allows teams to measure harm and the proportion of patients that are ‘harm free’ during their working day. For example, at shift handover or during ward rounds.” The safety thermometer looks at four areas of harm; pressure ulcers, falls (with harm), urine infection (catheters) and venous thromboembolism.
- Cley gynaecology and antenatal ward contributed information to the national safety thermometer and we saw that they had provided between 86% and 100% harm free care between January 2016 and January 2017. Although requested we did not receive figures for Blakeney Ward.
- The maternity unit did not contribute to the national Maternity Safety Thermometer. It was indicated during the inspection in 2015 that they planned to sign up to it in the future but this had not happened. They did use a maternity dashboard where key performance indicators such as activity, staffing and risk management were monitored on a monthly basis. Senior staff indicated that because they recorded information on their local dashboard they did not feel that it was necessary to sign up to the national maternity thermometer.

## Cleanliness, infection control and hygiene

- The areas we visited were visibly clean and tidy. We saw ample hand gel dispensers available at the entrances, exits and within all clinical areas and saw staff using them at the point of care.
- Staff adhered to the ‘bare below the elbows policy’ and we observed staff following good hand washing practice prior to, and following patient contact.
- Personal protective equipment such as disposable gloves and aprons were readily available in all areas and we saw staff using them appropriately.
- Equipment we saw was labelled with green ‘I am clean’ stickers showing the dates of last cleaning and there were ‘The 15 steps Challenge’ cleaning schedules for each area with ‘sign off’ sheets to ensure daily cleaning was performed. There were missing signatures on Cley and Blakeney wards which indicated that there was not good oversight of the cleaning schedules.

# Maternity and gynaecology

- The Midwife Led Birthing Unit (MLBU) and Delivery suite birthing pools were cleaned in line with the decontamination policy. Green 'I am clean' stickers were displayed on the doors to indicate ready for use.
- Staff knew how to access the infection prevention and control policies and procedures that were in place that were readily available to view on the trust's intranet.
- Clinical and domestic waste bins were available and clearly marked for appropriate disposal.
- We saw sharps disposal bins available in treatment areas where sharps may be used. We saw labels on sharps bins had signatures of staff, which indicated who constructed it, and on what date.
- We reviewed the bi monthly hand hygiene audits, for the period May 2016 to March 2017, for Cley and Blakeney wards, the Delivery Suite and the MLBU. These showed 100% compliance other than Cley Ward (gynaecological), where there were three months when compliance dropped to 97 and 98%.
- Staff on Cley and Blakeney wards submitted information to monthly 'high impact intervention' audits for urinary catheter care, peripheral intravenous cannula care and central venous catheter care. Cley gynaecological ward scored a persistent 100% compliance in these audits during the period April 2016 to February 2017, however on Cley obstetric and Blakeney wards, compliance varied between zero and 100%. Delivery Suite data was not supplied.
- There were no cases of methicillin resistant staphylococcus aureus (MRSA) bacteraemia, and one case of clostridium difficile on the maternity or gynaecology wards for the period April 2016 to March 2017, which was better than the national average.

## Environment and equipment

- All maternity and gynaecology services, including outpatient clinics, were located in the same area and on the same level. The neonatal intensive care unit was also located close by. This meant the environment was appropriate in preventing delays in transferring women and babies to these areas.
- There were two obstetric theatres, with their own teams. One for elective surgery and one for emergency procedures, and these were part of the delivery suite.
- The delivery suite and wards in women's services had locked doors. Staff used their identification cards to gain access, whilst visitors used a door buzzer system which

could only be accessed by staff at the reception desks who were able to observe the entrances. The delivery suite also had an intercom system for access; this meant women and babies were kept safe.

- The maternity areas had appropriate equipment available to provide care, such as cardiotocography (CTG) machines, which were used to monitor the unborn baby's heart rate and a mother's contractions.
- Baby resuscitaires, a specialist piece of equipment that is used for babies who may need some help with their breathing at birth, were available on the wards and in the delivery suite and were fully stocked, clean and ready for use. Staff checked and signed these daily.
- There was a board in the antenatal outpatient area with the names staff, advice on how to report on arrival and the waiting times for each clinician. The previous inspection indicated that there were not enough seats for women and partners however this was not apparent and all in the waiting area had seats.
- Adult resuscitation equipment was available in the delivery suite, wards, theatres and outpatient areas. The resuscitation trolleys were fully equipped in accordance with guidelines and all equipment and consumable items were within date. Daily checklists were consistently signed on all trolleys except for on Cley ward where there were missing checks on nine occasions throughout March 2017.
- We checked a range of consumable items for use by date and equipment including resuscitaires, scales, CTG machines, lamps, blood pressure monitors and ultrasound machines for electrical testing dates and calibration/maintenance dates (17 items). We found a set of manual scales with no calibration date and a lamp with no electrical testing date on Cley gynaecology ward. The senior ward nurse was informed. We were informed that the housekeeping staff had responsibility for checking these items and informing the estates department but we were unable to speak to the member of staff responsible during the inspection.
- The community midwives carried scales and blood pressure monitoring equipment with them. They were responsible for checking the calibration and maintenance dates and attending the hospital site to have items checked and serviced.

## Medicines

# Maternity and gynaecology

- All clinical areas within this service stored medicines in locked cabinets and medicine fridges. All medicines we checked were within use by date.
- Controlled drug (CD) medicines management was variable. On Cley and Blakeney wards, we found opened bottles of oral opiate liquids with no opening dates, which meant that staff could not ensure that medicine was within the recommended three months of opening.
- On Cley Ward the medication cupboard contained an opened vial of an injectable CD that had been partly used. The CD register indicated that the drug had last been administered and the part vial had been disposed of on the 26/02/2017. The CD register had been checked and signed as correct on three occasions since the drug was last dispensed. The anomalies were brought to the attention of the ward senior nurse. The part vial was immediately disposed of and the pharmacy and department lead were informed.
- There was confusion and lack of consistency with staff knowledge of frequency of CD drug checks and the CD register signed. On Cley ward the staff were not sure how often they should check CDs with one nurse suggesting it was daily and another indicated that pharmacy had said they could check every three to four days. The period between checks varied between; every three days and two weeks. Blakeney Ward and the delivery suite checked their CDs daily. The trust policy was to check at least once weekly and on administration. We were not assured that staff completed CD checks thoroughly in accordance with trust policy.
- We found missing daily medicine fridge temperature checks on Cley and Blakeney wards. There were 15 missing checks during the period January to March 2017, with 12 days missing in March on Cley ward. Blakeney ward had eight missing checks for the same period. This meant that staff could not be assured that medicines were always stored at the correct temperature. The temperatures that had been recorded showed no indications that were outside of safe storage of medicines.
- The resuscitation trolleys in each clinical area contained an emergency drug box and these were sealed and in date.
- We saw policies and procedures for the administration of antibiotics, which were compliant with the National Institute for Health and Care Excellence (NICE) standards.
- We reviewed six medication charts, all charts were signed, legible, had omitted medications checked and allergies were documented.
- Community staff carried a very limited amount of prescription only medication which they administered under patient group directives (PGDs). They also carried Entonox cylinders in their cars for use for women in labour in their own homes.

## Records

- Patient medical records were stored in unlocked cabinets on Cley and Blakeney wards. The cabinets were in an alcove behind the reception area but could be accessed by anyone as they could not be seen when staff were forward facing at the reception desk. Staff on Cley ward commented that the 'keys had been missing for a long time'. We were not assured that patient records were stored in a manner to protect their confidentiality.
- Records audits were completed monthly auditing 10 records randomly picked. The audits showed that the most poorly completed aspects were in dating, time, signing, name print and job title. These areas scored between 38% and 50% in the January to March 2017 audit report. The results of the audits were disseminated to all maternity staff via displaying results on the risk notice board, mandatory training and newsletters although there was no specific action plan to improve the results.
- Women on the delivery suite kept their medical records in the room with them and records accompanied women to the operating theatres and recovery room.
- We checked 14 patient records and found them to be contemporaneous, legible, dated and signed. The previous inspection noted that staff name stamps were available but we did not see these used.
- Women's hand held maternity notes provided a complete record of antenatal tests results in accordance with NICE guidelines, and individual care plans were documented and updated.
- Mothers were given the personal child health record, often called the red book, before they were discharged home. The red book was used to record the child's health and development. We saw that these were completed with child details before discharge.

## Safeguarding

# Maternity and gynaecology

- Trust safeguarding training target rates were 90%. Maternity and gynaecology staff did not meet this target, with 50% of medical staff trained to level two adults, and 41.7% trained to children's level two but none to level three training. Nursing and midwifery staff figures were higher, with level two adults at 71%, level two children at 81.8% and level three children at 79.6% indicating an overall 75.4% compliance. Since March 2014 there has been a requirement for midwifery and other clinical staff working with children, young people and/or their parents to complete level three safeguarding training. This requirement is outlined in the Royal College of Paediatric and Child Health intercollegiate document; Safeguarding Children and Young People: roles and competencies for health care staff.
- Safeguarding staff performed an audit of safeguarding discharge documentation in July 2016 and presented results in December 2016. Significant concerns were identified highlighting the lack of correct discharge paperwork being completed. The audit results were shared with all staff in midwifery and action to improve outcomes identified with a plan to re audit within six months.
- In a report submitted in March 2017 the safeguarding adult and children leads reported that the current trust wide pressures may have contributed to the recent decrease in compliance with safeguarding learning, with managers being unable to release staff to attend or provide time for staff to complete their mandatory training requirements. The named nurse for safeguarding sent a trust wide email to all managers reminding them of the importance and asking them to strongly encourage all staff to complete their e-learning packages.
- There was a trust wide safeguarding team, which was available Monday to Friday office hours. The team enabled staff to have direct access to information and support if they had a safeguarding concern. Staff we spoke to with knew how to access this service.
- All staff we spoke to were aware of their safeguarding responsibilities and described, both incidents of safeguarding, and the referral process.
- During the period December 2016 to February 2017, the maternity unit made 170 safeguarding referrals.
- There was a safeguarding link nurse for each area and a 'vulnerable women' specialist safeguarding midwife for those with mental health, substance misuse, domestic violence and female genital mutilation (FGM).
- Resources for staff were available on the trust's intranet, which we reviewed. Information was comprehensive and included checklists, risk assessments and referral forms staff could use to escalate concerns, as well as contact details of where further support could be obtained.
- Midwives assessed social vulnerability when women were initially booked into clinic. Staff requested extra information from a woman's GP or social services if deemed necessary. Midwives gave women information about relevant support services, (for example in respect of substance abuse, sexual abuse or a violent partner).

## Mandatory training

- Mandatory training was a combination of e-learning and practical sessions.
- The trust compliance target was 90%. The overall compliance figures for medical staff were 60.4% and 72.3% for nursing and midwifery staff. The training encompassed a range of 13 subjects for medical personnel and 17 subjects for nursing and midwifery staff, including adult and neonatal resuscitation, manual handling, medicines management, information governance and health record keeping. The lowest scores were for 'safe use of insulin' for both medical and nursing/midwifery staff scoring 30.8% and 25.3%. Staff explained that this was a new e-learning package. The highest scores were for 'blood transfusion' where medical staff scored 79% and nursing and midwifery scored 95.6%.
- Records of mandatory training were kept centrally and on individual 'electronic passports' for each staff member. Staff told us that they were supported to complete their training and given time to do e-learning and that this had improved over the last year with more staff in post.
- Mental Capacity Act, Deprivation of Liberty and Prevent radicalisation training was not well embedded and had only recently been restarted with both e-learning and face to face delivery programmes in place. We were not provided with figures for these subjects although staff told us that they had not received training in these areas during the previous year.

# Maternity and gynaecology

## Assessing and responding to patient risk

- There were daily 'safe hands' meetings to discuss any incidents in the previous 24 hours at the beginning of morning handovers on the delivery suite.
- The delivery suite and MLBU offered a triage telephone service answered by midwives, 24 hours, seven days a week. However the advice was not always consistent as different people answered the calls and there was no pathway or flowchart to follow. Advice was recorded on a form that was filed in patient notes but if the same person called several days in a row that information would not be available to those answering the telephone. The service was aware that this was not effective management but it was not on the risk register, and the IT midwife was in the process of liaising with the electronic record service to add a form to the system with links to current guidance.
- We reviewed 10 sets of medical records and saw that three out of five maternal records on the delivery suite and two out of five records on Cley gynaecology ward had incomplete World Health Organisation (WHO) Surgical Safety Checklist and five steps to safer surgery checklists with either missing signatures or not ticked. This was escalated to the division lead, and we were assured that processes had been put in place to improve practice.
- The WHO checklist tool was for clinical teams to improve the safety of surgery by reducing deaths and complications. The trust supplied WHO audit data compliance. The gynaecology surgery WHO audit showed that compliance was 100% from April 2016 to December 2016 but dropped to between 81% and 83% from January to March 2017. The maternity monthly audit figures were not supplied, but the overall compliance for the maternity theatres for the period April 2016 to March 2017 was 94.1%.
- The trust indicated that there had been changes in the format of printing of checklists in December 2016 which had impacted on their figures. Actions had been identified to monitor non-compliance and the quality of the checks. This included plans for improvement to be monitored monthly through theatre directorate meeting, and three monthly through the surgical division meeting.
- The trust used the Modified Early Obstetric Warning Score (MEOWS) to recognise physical deterioration in pregnant and postnatal women by monitoring their physical observations. A score greater than three triggered the use of a 'call out cascade' giving specific instructions regarding level of monitoring, referral for advice, review, and immediate actions to be considered.
- The trust audited MEOWS assessments for women scoring three or above on Blakeney ward. The audit of 93 MEOWS assessments reviewed for the period January to March 2017, showed 88.6% completeness of observations, 93% accuracy of observations and 75% response to triggers MEOWS assessments.
- Actions were identified to improve compliance with MEOWS and included, identification of MEOWS champions for each area, reviewing MEOWS assessments monthly across the other maternity clinical areas, and ownership of MEOWS assessment audit at ward level.
- Staff described the actions they would take in the event of a deteriorating patient and we saw four correctly completed MEOWS assessments in patient records.
- The service used an Obstetric Sepsis Screening Tool to assess women in whom an infection was suspected, or if their MEOWS score was greater than four. The tool gave clear instructions to follow, and the midwives we spoke to described the actions they would take if infection was suspected.
- Cley gynaecology ward used the National Early Warning Score (NEWS) and the Malnutrition Universal Screening Tool to monitor patients and we saw that records were correctly completed in the notes we reviewed.
- The women's division audited completion of venous thromboembolism (VTE) risk assessments. The audit of completion for the period April 2016 to March 2017 showed overall compliance of completed assessment to be 97.7%. It was noted that the figures for February and March 2017 had improved to 99.1%. Non completion of VTE assessments triggered an incident report and we saw that these were investigated in the electronic reporting system.
- The previous inspection reported that non-gynaecology transfer patients (known as boarders) to Cley gynaecology ward impacted on staff, as midwives were not registered to care for non-maternity patients. This meant that in the event that antenatal beds were used, the gynaecology staff were responsible for caring for increased numbers of patients with higher acuity (care needs). During the period April 2016 to March 2017 boarders occupied beds on 41 days with three

# Maternity and gynaecology

prolonged periods of eight to 10 days. Between 1st January and 7th March 2017, there were 24 days when there were at least 10 boarders on Cley ward with the majority from geriatric medicine.

- The previous inspection also reported that there were also concerns that boarded patients were not assessed regularly by their own medical teams. There were seven boarders on Cley ward at the time of inspection. These patients did not fulfil the informally agreed criteria for suitable patients to 'board' on Cley ward; for example stable post-surgical patients. Most were respiratory patients although notes review confirmed that they were seen by their medical teams daily. The trust were in the process of developing a Standard Operating Procedure to limit the type of boarders to those fulfilling appropriate criteria for the facilities, knowledge and skill of staff working on the ward.

## Midwifery and nursing staffing

- We found staffing levels were displayed on the entrance to all wards and there was a correlation between planned and actual staffing numbers.
- The trust used the BirthRate Plus tool for calculating the required midwifery staffing, and the manager on the delivery suite oversaw rosters on a daily basis to ensure safe staffing and move staff as appropriate. There was a staffing review in progress at the time of the inspection.
- The service monitored the NICE NG4 Staffing Red Flags on a daily basis in all clinical areas. A monthly report was presented to the Clinical Safety Sub-board, with the biggest number of red flags related to delays in triage on the delivery suite. The service reported that the delays were due to capacity rather than staffing levels and should improve when building works were completed for the new assessment and triage area.
- The service used the Safer Nursing Care Tool on the Cley gynaecology ward to determine the numbers of registered nurses on duty.
- Ward managers were supernumerary (not counted in ward establishment numbers), however, were able to support clinically if demand increased.
- The women's services employed 142 whole time equivalent (WTE) midwives, 14 specialist WTE midwives, 58.6 WTE community midwives, 15 WTE gynaecological outpatients and EPAU staff and 12.7 Cley gynaecology nursing staff. Following the last inspection, a business case agreed funding for a further 4.2 WTE midwives and

a WTE midwife sonographer. All posts have now been recruited to, and there was 5.8 WTE over establishment of midwives to ensure back fill of maternity leave, training needs etc.

- There were 2.9 WTE nursing vacancies on Cley ward, 5.5 WTE community midwife vacancies, and a 0.9 WTE gynaecology outpatient vacancy.
- Funding for a further three WTE midwives had been agreed for developing future elements of the service but not were yet recruited.
- Maternity care assistants (MCAs) and maternity support workers (MSWs) supported midwives, but we were not supplied with the figures for this group of staff.
- Midwifery staff told us that "staffing had improved in the last few months" and that they "felt there was generally enough staff".
- On the delivery suite, the trust reported a midwife to birth ratio establishment of 1:29.7 (one midwife for every 29.7 births per month). The trust recorded midwife to birth ratios monthly on the maternal dashboard and these showed improvements over the period April 2016 to February 2017 with a ratio of 1:33 at its worst to 1:30 currently. This did not meet the Royal College of Obstetricians (RCOG) Safer Childbirth Minimum Standards for the Organisation and Delivery of Care in Labour recommendations. However the figures provided for the period April 2016 to February 2017 showed they consistently achieved above their 80% target of women receiving 1:1 care with an average of 94.1%.
- Newly qualified midwifery staff rotated around the delivery suite, antenatal clinic, Cley obstetric and Blakeney postnatal wards, and the community. Some experienced midwives also chose to rotate to the community.
- Sickness absence rates had improved over the last year for hospital based midwives, falling from 6.99% in February 2016 to 4.94% in January 2017. The community midwife figures remained elevated at 7.14%.
- Cley gynaecology ward occasionally used agency staff when there were no available bank staff. Midwifery services, used bank staff on occasion but they did not use agency staff.

## Medical staffing

# Maternity and gynaecology

- Registrars and junior doctors on rotation supported the nine obstetric and 12 gynaecology consultant staff. The medical staffing skill mix showed the trust percentage of junior grade staff to consultant staff was about the same as the England average.
- The service provided 60 hours of consultant cover on the labour ward. This was in line with the guideline issued by “The Royal College of Obstetricians(RCOG): Safer Childbirth; Minimum Standards for organisation and delivery of care in labour, 2007” standards which state that units with between 2500 and 6000 births a year or classed as high risk should provide at least 40 hours a week of consultant presence. There was a consultant presence from eight am to seven pm five days a week on the delivery suite and on weekend mornings. On-call service began at seven pm weekday evenings but consultants stayed until all women at risk were seen and managed safely.
- A business case for the recruitment of two additional obstetric consultants had been agreed by the trust board and staff had been recruited but there had also been a recent retirement with another member of staff also due to leave which meant that the consultant posts were again being advertised.
- There was consultant anaesthetist cover for the obstetric unit from Monday to Friday, with weekends covered by an emergency on call rota, which was in accordance with Association of Anaesthetists of Great Britain & Ireland ‘Guidelines for Obstetric Anaesthetic Services’ 2013.

## Major incident awareness and training

- Midwifery staff were trained in the evacuation of mothers from birthing pools in the event of an emergency, and there were evacuation nets for use in an emergency.
- There was a major incident policy available on the trust website. A junior doctor recalled a recent emergency drill for postpartum haemorrhage on the delivery suite and we observed staff responding to an emergency call. This was done in a calm organised manner with each staff member obviously aware of their roles.

**Are maternity and gynaecology services effective?**

**Requires improvement**

We rated effective as requires improvement because:

- Patient outcomes were similar to the England average, but maternity dashboard outcomes such as the percentage of women breastfeeding at discharge, readmissions within 30 days and admissions to critical care unit consistently failed to meet targets.
- The service did not submit data to the national Maternity Safety Thermometer to enable itself to benchmark against other organisations.
- Appraisal information for the maternity and gynaecology nursing and midwifery staff showed that 67% of staff had received an appraisal within the last 12 months against a target of 90%.
- Electronic discharge letters were not always sent within 24 hours meaning women’s general practitioners were not informed of their hospital stay and outcome.
- The trust did not monitor the time from the anaesthetists being informed that a woman has requested an epidural to the time the epidural is performed which should not exceed 30 minutes and should only exceed one hour in exceptional circumstances.
- Community midwives did not have access to information technology, although this was in the process of being addressed there was no time schedule yet.

However:

- Staff provided care according to national guidance and evidence based practice and where they were not using guidance they risk assessed, reviewed and worked towards compliance.
- Staff contributed to a number of national audits and performed a range of local audits to improve women’s care and shared results.
- A range of pain relief methods was available to labouring women including birthing pools and hypnobirthing.
- There was good evidence of effective multidisciplinary team (MDT) working practices in place.
- The adjusted stillbirth rate was better than the national average with 19 stillbirths for the 5267 women delivered.

## Evidence-based care and treatment

# Maternity and gynaecology

- Staff provided care to people mostly based on national guidance, such as National Institute for Health and Clinical Excellence (NICE) guidelines, RCOG guidelines (including Safer Childbirth: minimum standards for the organisation and delivery of care in labour), and the recommendations from the MBRRACE-UK 'Saving Lives, Improving Mother's Care' 2016 report.
- MBRRACE-UK is a collaboration led from the National Perinatal Epidemiology Unit to run the national Maternal, Newborn and Infant clinical Outcome Review Programme (MNI-CORP) which continues the national programme of work conducting surveillance and investigating the causes of maternal deaths. The trust assessed themselves against key areas of the 'Saving Lives, Improving Mother's Care' report and we saw that they were compliant in 15 out of the 18 key areas and had actions to improve the remaining three.
- At our last inspection the service was non-compliant with NICE guidance (February 2015) for the management of gestational diabetes mellitus (GDM). At the time it was not included on the risk register. On this inspection the service was still non-compliant but had been risk assessed, was supported by the endocrinology department and the risk was included on the main risk register. There was evidence of a business case in progress to obtain investment to resolve the risk.
- The service was also non-compliant with; the Royal College of Obstetricians and Gynaecologists (RCOG) recommendation for screening for Small for Gestational Age foetus (Guideline 31), NICE Weight management in pregnancy (Guideline 27) and NICE Preterm labour and birth (Guideline 25). These were all included on the risk register and there was evidence of review and actions to mitigate risk and work towards compliance.
- Staff were aware of recent changes in guidance, and we saw evidence of discussion on NICE guidelines in people's health care notes and staff received monthly newsletters with recent changes.
- Termination of pregnancy was delivered according to the 1967 Abortion Act and supporting guidance.
- Staff were encouraged to participate and instigate audits and we saw that audit proposals came from a variety of staff and grades.
- We reviewed the audit schedule for 2016-2017. The maternity and gynaecology service completed a number of internal audits which included; Risk assessment of smoking in pregnancy: an audit of documentation in maternal handheld notes, Audit of

Hand Held Ultrasound Scanning to Prevent Undiagnosed Breech (Sign Up to Safety Campaign) and Audit on Management of Urinary Incontinence in women. We saw the audit data and the action points with recommendations for future repeat dates. This confirmed the service initiative to improve practice.

- Monthly audit meetings were held and learning shared with staff and at MDT governance meetings.
- All midwives were invited to attend the maternity service 'evidence based midwifery club' which met monthly to discuss new guidance.

## Pain relief

- Staff provided women attending antenatal clinic with information regarding the availability and provision of different types of analgesia and anaesthesia in accordance with Association of Anaesthetists of Great Britain & Ireland guidelines and a consultant anaesthetist was on call for the maternity unit 24 hours a day.
- Staff advised us there were no issues in obtaining pain relief or other medication for women. Staff reviewed birth plans with women in labour to accommodate their analgesia choices. All women we spoke with told us pain relief was effective and given when requested.
- Women in labour had access to tens machines, gas and air (Entonox), pethidine and epidural pain relief. Pethidine is a morphine-like opioid. An epidural is a type of local anaesthetic which numbs the nerves that carry the pain impulses from the birth canal to the brain. Staff transferred women requiring an epidural to the delivery suite. However, at the time of inspection, the trust did not monitor average wait times for epidural. The Association of Anaesthetists of Great Britain & Ireland states the time from the anaesthetists being informed that a woman has requested an epidural to the time the epidural is performed should not exceed 30 minutes and should only exceed 1 hour in exceptional circumstances. Therefore, the trust was not monitoring whether or not it was meeting this target.
- The community midwives spoke of a recent initiative set up with a small number of midwives trained to offer hypnobirthing classes. Hypnobirthing teaches simple self-hypnosis, relaxation and breathing techniques to help have a calmer, less painful birth.

# Maternity and gynaecology

- Birthing pools were available for women who wanted to use them during labour. Warm water is acknowledged to help women relax and make the contractions seem less painful.

## Nutrition and hydration

- Throughout the department we saw information posters and leaflets for breastfeeding including; expressing techniques, and details for local breastfeeding support groups.
- New mothers were supported on the delivery suite to breastfeed and a breast feeding support worker was available on Blakeney ward.
- Volunteer breastfeeding mothers also attended the ward to offer peer support to new mothers.
- Light diet was offered to women on the delivery suite post-delivery. All women and patients (unless nil by mouth) had access to drinking water and menu choices were offered to women on the wards.
- On Cley gynaecology ward we saw that the Malnutrition Universal Scoring Tool (MUST) was used to assess gynaecology and boarded patients.

## Patient outcomes

- CQC's Intelligent Monitoring found no maternity outliers for this trust.
- For the period October 2015 to September 2016 the trust's normal (non-assisted) delivery rate of 60.1% was similar to the England average of 59.8%, elective caesarean section rates were slightly higher at 12.5% than the England average of 11.6%, but the emergency caesarean section rates were lower at 14.7% against England average of 15.3%. Breech deliveries were the same as the England average and forceps delivery figures were slightly higher at 8.2% versus 7.1%.
- The adjusted stillbirth rate was better than the national average with 19 stillbirths per 5267 women delivered between April 2016 and February 2017. This equated to 3.6 stillbirths per 1,000 deliveries as opposed to the 4.5 stillbirths per 1,000 reported nationally in 2015 (most recent nationally available figure).
- The postpartum haemorrhage (PPH) rates of more than 1,500mls were monitored (3.2% for the period April 2016 to February 2017). The service also monitored 3rd and 4th degree perineum trauma, with 2.2% of women experiencing this during the period April 2016 to February 2017 as opposed to 2.3% nationally for the same period.

- We reviewed the service dashboard for April 2016 up to February 2017. The service recorded a number of clinical outcome indicators monthly, and used the traffic light system to identify if it was meeting targets. Green indicated successfully meeting a goal with amber and red indicating targets not being met and by how much. We saw that some goals were consistently green such as; the number of women delivered per month (target below 526), percentage of births using instruments such as ventouse and forceps and the number of born before arrival (BBA) of the midwife. Other targets such as; maternity readmission rate rates within 30 days, the service achieved the target on six out of the 11 months; this target was set by the Trust to monitor readmissions. Some targets such as breastfeeding at discharge had not been met throughout the dashboard period, with 63% against a target of at least 66% for exclusive breastfeeding at discharge and 68% against a target of at least 75% for breast/mixed feeding. There were eight women admitted to the critical care complex during the same period against a target of none.
- The maternity and gynaecology service completed a number of internal audits such as; risk assessment of smoking in pregnancy: an audit of documentation in maternal handheld notes, audit of hand held ultrasound scanning to prevent undiagnosed breech (Sign Up to Safety Campaign) and audit on management of urinary incontinence in women.
- We saw the audit data and the action points with recommendations for future repeat dates. This confirmed the service initiative to improve practice.
- The trust contributed data to the 2015 National Neonatal Audit Programme (NNAP) and to the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK (MBRRACE-UK). In the NNAP audit the trust performed the same as or better than the England average in five out of six measures. The only one where they performed worse, was for mothers who deliver babies between 24 and 34 weeks gestation given any dose of antenatal steroids. The trust figures were 82% against an England average of 85%.
- The trust had been awarded UNICEF BABY Friendly Initiative (BFI) level 3.

## Competent staff

# Maternity and gynaecology

- Newly qualified midwives completed a comprehensive preceptorship programme. Preceptorship packages were individualised and provided a framework to develop staff from a band five to a band six in maternity care. This included rotation across all sites.
- The role of the Supervisor of Midwives (SoMs) was discontinued in early 2017 in line with national guidance and requirements. The trust had instigated a new supervisory model as from 28th of March 2017. The new model introduced Professional Midwifery Advocates (PMAs) who required specific training. The existing SoMs had agreed to continue in a supervisory role until the model was in place ensuring continuation of supervision.
- Appraisal information for the maternity and gynaecology nursing and midwifery staff showed that 67% of staff had received an appraisal within the last 12 months. The highest rate was on Cley obstetrics where the rate was 78%. The MLBU had a rate for the year of 61.6% per cent appraisals completed rising to 80.6% for March 2017 following increased activity to improve the appraisal rate.
- The trust supplied appraisal data for medical staff, but this was not broken down into departments so we were unable to confirm if all obstetric and gynaecology medical staff had completed appraisals. The information supplied showed; of the 180 trust doctors due to have an appraisal during the preceding 12 months, 173 have done so (96%). Of the seven remaining clinicians there were two doctors for whom the reporting officer accepts the postponement is reasonable.
- Staff told us that appraisals were meaningful and provided opportunities to discuss career progression and learning opportunities.
- Practice development newsletters were sent out monthly and included pertinent information such as; new guidelines introduced, mentorship and accessing mandatory training.
- Junior doctors attended protected weekly teaching sessions and participated in clinical audit. They told us they had good support from senior medical staff and could approach them for advice at any time. There was a weekly trainee forum where doctors could raise any training issues.
- Junior doctors said they were very happy with the training and support they received, particularly that given by consultants. There was a good induction process and mandatory training was provided.
- Nursing and midwifery staff were supported to achieve revalidation and those that had been through the process 'found it useful and thought provoking'.

## Multidisciplinary working

- We observed good interaction between medical staff and midwives with decision making on women's management in labour.
- Observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team (MDT) working practices were in place.
- Handovers were multidisciplinary with all attendees encouraged to contribute.
- The senior Neonatal intensive Care Unit (NICU) nurse visited the delivery suite each morning to go through the board, and discuss potential admissions and high risk patients.
- Paediatricians attended the governance meetings.
- Physiotherapists were available to support women during the working week with a limited service at weekends. Women and staff advised us there was good access and the service was responsive.
- Staff confirmed there were systems to request support from other specialities such as pharmacy, allied healthcare professionals and physicians.
- Communication with community maternity teams was by telephone. The community midwives felt they had good support from the trust and regularly attended the trust site for training and restocking of equipment and Entonox cylinders. The night duty community midwives worked from the hospital site.
- Community staff regularly worked from GP surgeries and staff said they had good communication with women's GPs during antenatal care.
- The trust sent electronic discharge letters (EDLs) to GPs to inform them of inpatient discharges from hospital. The trust monitored submission as part of its monthly performance monitoring, with the target; for all EDLs to be completed within 24 hours of discharge. We saw the EDL rates for maternity and gynaecology for the period April 2016 to February 2017 which showed that EDL completion varied between 61% and 73% indicating

# Maternity and gynaecology

that they were not meeting the target and that GP's would not always be informed about a women's discharge in a timely manner. There was working group meeting led by a consultant to identify improvements.

## Seven-day services

- Cley gynaecology and obstetric ward, Blakeney postnatal ward, the delivery suite and MLBU were operated 24 hours a day, seven days a week.
- The early pregnancy unit (EPAU) was available seven days a week. Women who required emergency early pregnancy advice also attended Cley gynaecology ward if their pregnancy was less than 22 weeks. Women more than 22 weeks pregnant were seen on the delivery suite.
- The obstetric consultant service was available during the day five days a week and weekend mornings (60 hours) and there was an on call rota for out of hours. Staff confirmed that if called they were available by telephone and attended quickly when needed.
- Community midwives offered seven day services for home births.

## Access to information

- The maternity service had an electronic medical records system with access to laboratory investigations. Women also kept paper hand held notes with them for the duration of their pregnancy. The gynaecology service used a paper based notes system.
- Staff accessed national guidelines through the trust's intranet, which was readily available to all staff in the hospital. Midwifery staff demonstrated accessing the system to look for the current trust guidelines.
- Community staff had limited access to information. Staff completed initial assessment details on paper forms which then had to be copied over to the electronic system. Six of the nine teams had a base office and only two had electronic records access. Staff attended the hospital site or could access some hospital website information such as guidelines, but not patient sensitive information, from their personal computers at home. Electronic access was on the risk register and funding had been agreed from charitable funds to provide them with laptops within the near future.
- We reviewed 12 clinical guidelines and policies, including Induction of Labour, and Instrumental Delivery and found these were within date, version controlled and in line with evidence based practice.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust consent policy was based on guidance issued by the Department of Health. This included guidance for staff on obtaining valid consent, details of the Mental Capacity Act 2005 (MCA) and checklists.
- Consent forms for women who had undergone caesarean sections detailed the risk and benefits of the procedure and were in line with Department of Health consent to treatment guidelines.
- There was a system to ensure consent for the termination of pregnancy was carried out within the legal requirements of the Abortion Act 1967. We looked at a sample of consent forms during our inspection and found these records met legal requirements.
- Staff had generally limited knowledge of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards, but could describe where they would obtain information and support. Documentation supplied by the trust acknowledged that MCA and Deprivation of Liberty training had not been available for a period of time and had only recently recommenced.
- Staff on Cley gynaecology ward demonstrated more knowledge as they often cared for patients with more long term complex conditions.

## Are maternity and gynaecology services caring?

Good



We rated caring as good because:

- Women we spoke with were very positive about their treatment by all clinical staff and the standard of care they had received.
- The trust's Maternity Friends and Family Tests (FFT's) were generally better than the England average, with scores between 97% and 100% against England scores of between 94 to 97%.
- Women were involved in their choice of birth at booking and throughout the antenatal period. In antenatal clinics, women were given information regarding different birthing settings early on in their pregnancy, including the benefits and risks of home birth.

# Maternity and gynaecology

- There was a family support post funded by an external organisation to support women and families with pregnancy loss or fetal surgery.
- Partners were complimentary about the care and support provided by staff. They felt included and were offered the option to stay overnight in specially bought recliner chairs.
- Cley gynaecology ward had a bereavement baby memento bag/box for parents, which contained a form to acknowledge the existence of a foetus born before it was viable (as a birth certificate could not be issued) and tiny hand knitted garments for stillborn babies to have photographs for parents.

## Compassionate care

- Between January 2016 and January 2017, the trust's Maternity Friends and Family Tests (FFT) were generally better than the England average, with scores between 97% and 100% against England scores of between 94 to 97%. Cley gynaecology ward FFT was consistently 100% for the period February 2016 to November 2016 but dropped to 98% in December and January 2017.
- Women we spoke with, on both the gynaecology and maternity wards, were very positive about their treatment by all clinical staff and the standard of care they had received. Four women told us that their experience had improved significantly with their most recent pregnancy compared to experiences a couple of years ago.
- Women and their partners described staff as being 'amazing' and that 'they could not have been any better'.
- Women told us they had a named midwife. They felt well supported and cared for by staff, and their care was delivered in a professional way.
- We observed staff interacting with women and their relatives in a polite, friendly and respectful manner. There were arrangements to ensure privacy and dignity in clinical areas.
- The handover board in the delivery suite was situated in the main corridor and had a roller blind to cover women's names and protect their confidentiality.
- Partners were complimentary about the care and support provided by staff on Blakeney ward. They felt included and were offered the option to stay overnight in specially bought recliner chairs.

- Birthing partners were included and involved in the birth process, being encouraged to assist with physical and emotional support for women and were offered the option to cut their baby's cord.
- We observed two elective caesarean sections. One woman was particularly anxious as she had a bad experience previously. Staff were empathetic and patient allowing the woman time to adjust and reassuring her that all was going as planned.
- Staff protected the women's dignity and displayed a caring attitude towards her and her birthing partner. Staff suspended one procedure for a short period, to enable the woman to receive anti-sickness medication, and were reassuring regarding the process.
- During the caesarean sections the theatre staff put women and partners at ease, making conversation and asking them general questions about babies names and family life.
- The trust performed about the same as all other trusts for all 16 questions in the CQC Maternity Survey 2015.
- Multifaith support was available for bereaved parents through the chaplain service and staff also had access and links to outside charitable support agencies.
- Cley gynaecology ward staff showed compassion for women presenting with miscarriages and allowed partners to stay with women to provide support.
- Staff treated women undergoing termination of pregnancy with dignity and discussed the need for understanding, making sure women had the opportunity to discuss their concerns and being non-condemnatory with women's choices.

## Understanding and involvement of patients and those close to them

- Women were involved in their choice of birth at booking and throughout the antenatal period. In antenatal clinics, women were given information regarding different birthing settings early on in their pregnancy, including the benefits and risks of home birth.
- Women advised us they were given regular opportunities to discuss their health, concerns and preferences.
- Birthing partners were included and involved in the birth process, being encouraged to assist with physical support for women and were offered the option to cut the babies cord. Birthing partners attended epidural caesarean sections and were able to sit beside the mothers head to support her during the procedure.

# Maternity and gynaecology

- We observed a patient who had a procedure and the anaesthetists explained what would happen and checked their understanding before going ahead.
- The women having caesarean sections confirmed that the surgeon gave a full explanation of what would be done and the risks and benefits of treatment, on the ward prior to the procedure. We observed the surgeons checking again immediately prior to surgery that the women and partners understood everything.
- Women seen in the gynaecology clinic confirmed that they were involved in decision making about their care and fully informed prior to consenting for surgery and procedures.

## Emotional support

- Antenatal documentation included assessments for previous and ongoing mental health issues.
- There was a specialist midwife for substance misuse and mental health, and the trust were developing a 'vulnerable women' team to provide support for safeguarding and domestic violence to women in clinics and at home.
- Bereavement policies and procedures were in place to support parents in cases of stillbirth or neonatal death.
- Cley gynaecology ward had a bereavement baby memento bag/box for parents, which contained a form to acknowledge the existence of a foetus born before it was viable (as a birth certificate could not be issued) and tiny hand knitted garments for stillborn babies to wear for photographs for parents to keep.
- A midwife attended the fetal medicine clinic to support women and families who may be given bad news.
- There was a family support post funded by an external organisation to support women and families with pregnancy loss or fetal surgery.
- Midwives led a birth reflections clinic, which provided women with an opportunity to have unresolved issues about their pregnancy or birth experience answered.
- One woman told of how much she appreciated the support staff offered her and that they attended the funeral of one of her other children during her pregnancy.
- The community midwives spoke of referral to charitable outside agencies who offered counselling services to bereaved parents.

## Are maternity and gynaecology services responsive?

Good



We rated responsive as good because:

- Services were planned, delivered and co-ordinated to take account of women with complex needs, there was access to specialist support and expertise from medical and nursing and midwifery staff.
- The maternity service ran a number of clinics for patients with complex needs. These were managed by specialist midwives and consultants.
- The maternity service achieved an overall 91.2% of maternity booking appointments for delivery before 12 completed week's gestation against a target of at least 90%.
- The hospital had 'Breastfeeding Peer Supporters' who volunteered across the service, and were on hand to offer support, listen to any mother's experiences and worries, and give advice on aspects of breast feeding and skin to skin contact.
- We reviewed complaint records and responses and saw that these were investigated and replied to in a timely manner.

However:

- The gynaecology service did not meet its referral to treatment (RTTs) waiting times. There were 2543 patients on the gynaecology 18 week RTT incomplete waiting list and a backlog of 617 patients waiting up to 45 weeks for treatment.
- The delivery suite closed to labouring women on nine occasions between May 2016 to February 2017 due to capacity and staffing issues meaning women had to travel to other units.

## Service planning and delivery to meet the needs of local people

- Services were planned, delivered and co-ordinated to take account of women with complex needs, there was access to specialist support and expertise.
- The previous inspection in 2015 noted concerns regarding an obstetric assessment unit (OAU) for single point of entry based on Cley ward. The concerns related to mainly the location on Cley ward and the staff

# Maternity and gynaecology

support. This had been discontinued before our inspection and assessment for pregnant women of more than 22 weeks gestation took place in three rooms on the delivery suite.

- The service was aware of its risks and the need to ensure that services were planned and delivered to meet the increasing demands of the local and wider community. The antenatal and gynaecology clinics were outgrowing the facilities and there was consideration into using space at outreach locations to improve accessibility and efficiency.
- Women were given a choice of times and dates for antenatal clinic appointments. Maternity services aimed to ensure that women had a named midwife whom they saw at their first appointment. Women might not see that midwife at every appointment but would see one of a small team at that clinic.
- The delivery suite had an agreed business plan to convert the current staffroom into four bedded triage/assessment unit as the current triage and assessment took three delivery rooms which reduced capacity.
- There were plans to improve one of the delivery rooms to make it suitable as a bereavement room.
- Women admitted on to Cley gynaecology ward for a termination of pregnancy were always admitted to a single room ensuring that they did not come into contact with women admitted with pregnancy complications.

## Access and flow

- Between July 2015 and December 2016, the occupancy levels for the trust's maternity beds were higher than the England average for the first 12 months and then fell below the average in the last six months. The occupancy ranged from 73% at its highest to its lowest at 47%. The England average for those periods was 61% and 59% respectively.
- The delivery suite closed on nine occasions during the period May 2016 to February 2017 which was an improvement on the 21 for the same period in the previous year. The closure periods of time varied between five hours and 67 hours and 40 minutes. The reasons given for the closures were due to capacity and short staffing although the trust confirmed that no closures were due to short staffing since October 2016

but related to high acuity. This meant that during these closures, 19 women in labour were redirected to maternity units at other hospitals which involved travelling for more than 30 minutes.

- The gynaecology service did not meet its referral to treatment (RTTs) waiting times at our last inspection in 2015 and this had not improved for the period April 2016 to February 2017. The only target that they did meet was the cancer two week wait, which was 96.5% against trust target of 93%. The gynaecology cancer 62-day target for referral to treatment was 62.3% and did not meet the 85% target, the cancer 62 day screening was 40.9% against a 90% target and 31 day cancer treatment target was 92.7% against a target of 96%. We reviewed the remedial action plan and saw that there was identification of needs and several options being investigated, including increased numbers of consultants' signed-off to perform outpatient procedures, using operating theatres at other locations and other providers and recruitment of consultant staff. Entries were dated and identified the person responsible for actions.
- For routine referrals the 18 week incomplete pathway is the national measure for patients referred by their GP for treatment, to starting treatment. Between April 2016 and February 2017 the trust performance was 83.3% against an England average of 90%, with 2543 patients on the incomplete waiting list and a backlog of 617 patients waiting up to 45 weeks for treatment. This was on the trust risk register and actions were in place such as; additional weekend theatre lists, increased capacity in clinics, outsourcing procedures to local independent healthcare providers. There were 89 gynaecology operations cancelled between April 2016 and February 2017. Of the six cancelled operations in February, all were due to lack of operating theatre time and rebooked within 28 days.
- Between April 2016 and January 2017, the maternity service achieved an overall 91.2% of maternity booking appointments for delivery before 12 completed week's gestation against a target of at least 90%. We saw that performance had been below 90% for five or the first six months, but had improved and was consistently above 90% during the last four months.
- Women received an assessment of their needs at their first appointment with the midwife. The midwifery package included all antenatal appointments, ultrasound scans and routine blood tests.

# Maternity and gynaecology

- The outpatient clinics had boards with staff names, advice on how to report on arrival and how long the waiting times were.
- Gynaecology clinics were well managed and ran smoothly but there was limited capacity, extra clinics were being introduced but this impacted on staffing requirements.
- The fetal medicine clinics were operated by three consultants and managed by a lead specialist midwife and antenatal screening coordinator assisted by two specialist midwives. The team held clinics four days per week and offered an appointment within 5 working days of an identified concern.
- The three bedded pregnancy and wellbeing unit was available week days for women who required assessment and care to women whose pregnancy required closer monitoring. Referrals were made by the community midwife, GP, maternity wards or women self-referring. Investigations such as oral glucose tolerance tests were performed there.
- Women needing gynaecology emergency access to treatment were admitted via the accident and emergency department. Pregnant women accessed treatment either direct via the delivery suite or Cley ward if under 22 weeks pregnant.

## Meeting people's individual needs

- The maternity service ran a number of clinics for patients with complex needs. These were managed by specialist midwives and consultants and included specialist clinics for; vulnerable women, vaginal birth after caesarean section, type one diabetes, gestational diabetes, fetal medicine, breech management, hypertension/renal impairment, multiple pregnancy and pre-op clinics. Links were made with the relevant specialists elsewhere in the hospital, to ensure that a joint approach met women's needs.
- Experienced midwives monitored a trust maternity social media site where women could comment and ask questions.
- The service used both interpreters and a telephone translation service to communicate with women with whom English was not their first language.
- There was a range of information leaflets available to women, for both gynaecology and maternity. Staff told us these leaflets were available in different languages if required.
- There were link nurses and midwives to support women with learning disabilities and a purple pictorial folder for those with a learning disability on each clinical area. The folder used pictures and simple, easily understood language to show procedures and answer questions.
- One midwife gave an example of a woman with a learning disability on the delivery suite. A care plan was put in place and there was support from the woman's social worker.
- There were specialist vulnerable women midwives to provide support for those with complex needs such as domestic violence, teenage pregnancies and female genital mutilation.
- There were processes to ensure disposal of pregnancy remains were handled sensitively. Women were provided with a choice of how they would like to dispose of pregnancy remains, following pregnancy loss or termination of pregnancy.
- The hospital had 'Breastfeeding Peer Supporters' who volunteered across the service, but mainly on Blakeney ward. They acted as a "well informed friend" or mentored new mothers and were on hand to offer support, listen to any mother's experiences and worries, and give advice on aspects of breast feeding and skin to skin contact. The volunteers had all undertaken training provided by The Breastfeeding Network (BfN) Charity, the National Childbirth Trust (NCT) or the Association of Breastfeeding Mothers (ABM). They had also completed the Breastfeeding and Relationship Building course to UNICEF standards, and attended supervision at least six times a year with the infant feeding co-ordinator as well as annual updates.
- The community midwives provided preparation for parenting classes to build confidence, and prepare parents physically and emotionally for pregnancy, labour and birth. They also helped gain insight into the transition to parenthood, including practical care of a new baby. The classes provided a forum for meeting other prospective parents to share ideals and knowledge. The classes were held at different locations and times including evenings to enable women and birthing partners to attend.
- Women in labour had access to bean bags, birth balls, birth mats, and a birthing pool for their comfort.
- The Midwife Led Birthing Unit (MLBU) had rooms with light projectors and electronic candles to create a calm soothing atmosphere.

# Maternity and gynaecology

- The Early Pregnancy Assessment Unit (EPAU) was located near the outpatient area and meant that women did not pass through a post-natal ward to access the service.
- Women attending for a termination of pregnancy were admitted direct to side rooms on Cley gynaecology ward to limit contact with women with pregnancy complications.

## Learning from complaints and concerns

- Patient advice and liaison service (PALS) information was displayed in prominent areas on the wards and outpatient areas and provided information on how to raise a complaint.
- Senior staff reviewed complaints weekly and distributed to responsible officers for investigation and response. Complaints were reviewed monthly in the clinical performance meeting.
- We reviewed the ward and departmental meetings and saw that complaints were discussed and findings shared.
- We reviewed complaint records and responses and saw that these were investigated and replied to in a timely manner.
- Between April 2016 and February 2017, 116 complaints were received by the women's and children's division. Complaint themes included staff attitude and long waits for induction of labour. We saw that these issues were addressed in departmental meetings and in the governance presentations.

## Are maternity and gynaecology services well-led?

Good 

We rated well-led as good because:

- There was strong leadership demonstrated from the senior management team.
- There was a clear vision and strategy for the maternity service.
- Staff were appreciative of recent changes and felt that management were visible and supportive.
- The staff said that they felt that the service was running better with the new Head of Maternity in place and that they felt they were 'listened to'.

- The senior management had oversight of clinical risks and there was evidence that risks were regularly reviewed and updated with named ownership of risks.
- Staff reported that a 'no blame' culture was evident in the trust and felt they could report errors or omissions of care and use them to learn and improve practice.
- There was an active maternity services liaison committee (MSLC) which met every three months and had input into making changes such as translation of information leaflets.
- There was a strong drive to improve and develop with multiple innovations including the development of the IT system and the Baby University scheme.

However:

- There was a lack of ownership at ward management level of issues such as checking resuscitation equipment, ward cleaning and medication checking.
- The trust staff survey was completed by 32% of staff in the women and children's division. The trust's score of 3.70 was in the lowest (worst) 20% when compared with trusts of a similar type.
- Three of the six community midwives we spoke to on different teams commented that they felt they had been either verbally abused or witnessed verbal abuse of a team member by their immediate supervisor.
- The gynaecology nursing staff on Cley ward felt that the impact of medical patients and increased acuity of those patients meant that they were often short staffed and 'cut off' from the rest of the service.

## Leadership of service.

- The maternity and gynaecology service was part of the women and children's division.
- Professional leadership of maternity and gynaecology was through a medical, clinical divisional lead, a divisional nursing director and the head of midwifery (HoM), who joined the service following the last CQC inspection in 2015.
- Each clinical area was managed by a band seven lead nurse who reported to a matron. The matrons reported to the HoM. We observed strong leadership from the senior team members but this was not always apparent at ward management level.
- The maternity and gynaecology services related to the trust board through the director of nursing. There was a

# Maternity and gynaecology

neonatologist who acted as the service champion for the maternity and gynaecology team on the trust board and we saw that there was oversight of the service in minutes of a board meeting in December 2016.

- Ward nurses and midwives spoke positively about the matrons. They said they were supportive, wore uniform and were hands-on when necessary.
- We saw good examples of teamwork at ward level but there was a lack of ownership of ward level issues such as checking resuscitation equipment, ward cleaning and medication checking.
- The community midwives were less positive and three of the six midwives we spoke to on different teams commented that they felt they had been either verbally abused or witnessed verbal abuse of a team member by their immediate supervisor. We were not able to discuss this with senior leaders as it was not identified until after the inspection. The Trust have informed us that they are investigating these concerns and that there was a consultation in progress regarding the service at the time of inspection.

## Vision and strategy for this service

- Staff were aware of the trust PRIDE values (people focused, respect, integrity, dedication and excellence). Staff at the hospital site felt that this was embedded throughout the women's and children's directorate. Three of the community midwives we spoke to felt that the values were less embedded in the community.
- There was a clear vision and strategy for the maternity service, with the strapline 'Delivering the best'. The strategy had four key aims; to be women focused, deliver high quality care, to be seen as the shining star leading with initiative and creative ideas and to be efficient and effective with resources. The challenges were identified and there was a clear plan for the first year with long term ambitions also identified, however not all staff knew the service vision and strategy.
- The head of midwifery was acknowledged as the driving force behind the strategy with staff recent changes. The strategy plans were shared with staff across the division with a strategy presentation in February 2017.
- Staff were encouraged to contribute to the vision and strategy and we were told of changes that had been made following a band seven meeting, to improve the flow and triage in the delivery suite.

- A band six midwife was involved in making changes to plans to convert rooms on the delivery suite to an assessment room.

## Governance, risk management and quality measurement

- There were 20 maternity and gynaecology risks on the trust risk register. The risks were rated and regularly updated. The risk register reflected risks identified on inspection, such as the need to improve the availability of information technology (IT) connectivity in the community. This impacted on timely recording of patient care and possible inaccuracies from the mix of paper and electronic records. The governance lead, risk lead midwife, matrons and the HoM had good oversight of the risks.
- The trust used a maternity dashboard to monitor key areas as recommended by the Royal College of Obstetricians and Gynaecologists (RCOG). The dashboard used the traffic light system to denote whether they were meeting clinical targets with green indicating compliance and amber and red indicating noncompliance.
- We reviewed the morbidity and mortality meeting minutes from January, February and March 2017 and saw that the meetings were well attended by medical staff of all grades and midwives and nurses as well as clinical and governance leads. The minutes included 'lessons learned', recommendations, and arrangements for shared learning.
- There was a full time risk midwife and clinical lead to support the governance process. They reviewed incident reporting, compliance with guidelines, performance and outcomes. They produced a monthly presentation which identified current risks, incidents and themes, complaints, audit results, and maternity dashboard results and divisional updates were presented to trust clinical governance meetings every three months.
- There was a maternity risk management meeting weekly where incidents and identified themes were discussed, and a monthly 'Risk Update' newsletter which highlighted current risks and progress.
- The maternity service employed an information and technology (IT) midwife who worked closely with the external electronic record system supplier to ensure that the system was suitable for use. They were in the process of evaluating and making changes to enable capture of triage telephone calls to the delivery suite to

# Maternity and gynaecology

ensure consistency of advice and links to guidance documents. The IT midwife also chaired a system user group to share changes and good practice with other trusts.

## Culture within the service

- Staff said that the current women's and children's senior management were very visible and approachable although they reported that the executive team were less so and four junior staff were not able to recall the chief executive's name.
- Midwives and medical staff were proud to work at the hospital and were committed to providing a good service. Many members of staff commented on the excellent teamwork, respect for each other and shared values.
- We observed excellent multidisciplinary working between midwifery and medical teams and it was clear that there were strong working relationships, and respect for team members skills, from junior staff through to the most senior leaders.
- There was a feeling amongst the hospital teams that they were working more effectively with all grades of staff.
- Staff reported that a 'no blame' culture was more evident in the trust. Staff said they could report errors or omissions of care and were encouraged to reflect on incidents as soon as possible and use these to learn and improve practice.
- Trainee doctors were positive and said there was good working relations and support. The working environment was described as 'friendly.'
- The service had developed a workforce Wednesdays meeting attended by the clinical and clerical managers to focus on workforce issues and supporting staff. The ethos was for managers to take more ownership of staffing issues and to 'know their staff'.
- Women and children divisional forum 'drop in' sessions were held fortnightly for all staff.
- Matrons held monthly dashboard meetings and were encouraged to attend divisional boards.
- The community midwives (CMWs) responses were mixed with three of the six CMWs feeling that there was a better, more supportive culture within the hospital than in the community setting.

## Public engagement

- There was an active maternity services liaison committee (MSLC) which met every three months. We saw the notes of the meetings in January 2017 and saw that this was well attended by senior midwives, clinicians and users of the service. Current themes and issues were discussed and the forum had input into work on translation and clarity of leaflets.
- The midwives monitored a trust social media site (Bumps and Babies) for women to comment and ask non urgent questions. We saw that simple reminders and advice were given and the content was suitable for a social media site. There were numerous thank-you responses from grateful parents.
- The delivery suite did not offer routine pre admission visits but this was available on the midwife led birthing unit by appointment and dependent on capacity.

## Staff engagement

- The HoM had involved staff in developing the midwifery strategy and staff felt they were engaged in making efficiency changes.
- The staff said that they felt that the service was running better with the new HoM in place and that they felt they were 'listened to'.
- Staff told us they had regular team meetings and information was delivered in a variety of ways; face-to-face, email, and newsletters.
- The community midwives (CMWs) were incorporated as part of the overall maternity team and felt they had good contact with the hospital service. They were looking forward to the long awaited IT access and felt it would strengthen their links, however three of the CMWs felt that local community management was not always respectful or professional in their behaviour, although they had not reported this to senior management due to a fear of reprisals.
- The gynaecology nursing staff on Cley ward were less engaged and confirmed that although they were supported, they felt that the impact of medical patients and increased acuity of those patients meant that they were often short staffed and 'cut off' from the rest of the service.
- Trust senior staff told us about "Speak up guardians" who were individuals who would "speak up" on behalf of staff who felt unable to raise concerns individually. Only two of the staff we spoke to were aware of them.

# Maternity and gynaecology

- The trust staff survey was completed by 32% of staff in the women and children's division. The trust's score of 3.70 was in the lowest (worst) 20% when compared with trusts of a similar type.

## Innovation, improvement and sustainability

- Funding had been agreed to convert non-clinical rooms on the delivery suite to incorporate a four bedded assessment unit which would free up the delivery rooms currently being used and increase capacity. The staff were excited and had been involved in the design and concept.
- The hospital received funding January 2017 following a successful bid to the Department of Health's Maternity Innovation Fund and the Maternity Safety Training Fund to provide additional training for staff. The Maternity Innovation Funding was for a new piece of simulation technology called 'CTGi' which replicates a baby's heart rate pattern during labour. This piece of training technology will be used within clinical areas for both the midwifery and medical teams and supplement more traditional class room tutorials and e-learning programs.
- The trust were investing in training a midwife sonographer to improve ultrasound services.
- The service had recognised that there would be a need for more gynaecological procedures delivered in the outpatient clinics in the future and were investing in training for gynaecology nurses to undertake hysteroscopy.
- The service was engaging with local healthcare providers to provide a new specialist inpatient care unit for mothers with mental health needs.
- The trust was about to launch the 'Baby University' scheme. Every new or expectant mum that signs up for the scheme will receive a Baby Box made from a very thick cardboard, a firm foam mattress, waterproof mattress cover and a cotton sheet. The scheme replaces the need for a traditional Moses basket or cot, and it is thought the small size of the Baby Box helps to prevent sudden infant death syndrome.
- The service had recently introduced the 'Red:Green days' system to assist in the reduction of internal and external discharge delays. The system uses simple rules to help reduce delays for patients by making non value adding days (from a patient's perspective) visible and a daily topic of conversation for clinical and managerial staff.
- Key members of staff had recently undertaken 'human factors' training with the plan to roll out learning across the directorate. Human factors is a broad discipline which studies the relationship between human behaviour, system design and safety through an understanding of the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour and abilities and application of that knowledge in clinical settings.
- The IT midwife was innovative and passionate about ensuring that IT equipment and services were appropriate for the service and was pioneering new ways of using the IT system which could be rolled out to other trusts.

# Services for children and young people

Safe	Requires improvement	
Responsive	Good	
Well-led	Good	
<b>Overall</b>		

## Information about the service

The Norfolk and Norwich University Hospitals NHS Foundation Trust provides services for children and young people, comprising of a tertiary level three neonatal unit and a children's department named the Jenny Lind Children's Hospital.

The neonatal unit has 42 cots, inclusive of nine intensive care cots, six high dependency cots, 22 special care cots and five transitional care cots. Babies born between 23 weeks of pregnancy and 44 weeks of pregnancy are cared for in the unit, with the provision of neonatal surgery when required.

The Jenny Lind Children's Hospital comprises of the children's outpatients department; a children's assessment unit; a children's day ward; a children's ward named Buxton ward; and the provision of six beds on the day procedure unit named Lion ward. There are 10 clinic rooms in the children's outpatients department; eight beds, two side rooms and a treatment room on the children's assessment unit; three beds and a treatment room on the children's day ward; and 33 beds including four high dependency beds on Buxton ward.

The trust had 9850 hospital admissions for children between December 2015 and November 2016, of which 90.7% were emergency admissions and 8.3% were elective admissions.

During the inspection, we visited the neonatal unit, the children's outpatients department, the children's assessment unit, the children's day ward, Buxton ward, Lion ward, and theatre recovery.

We spoke with six parents or carers, 21 registered nursing staff, four support staff including health care assistants and nursery nurses, nine medical staff, and three housekeeping staff. We reviewed 21 sets of medical records and information requested by us and provided from the trust.

# Services for children and young people

## Summary of findings

- Patient care records were clear, detailed, and contained all necessary information.
- Additional security measures had been introduced throughout the children and young people's service. All areas were found to be secure during our inspection. This addressed concerns raised during our previous inspection.
- Staff were knowledgeable about the incident reporting process. There was evidence of learning and communication to staff regarding outcomes of investigations.
- Staff across the children and young people's service were knowledgeable about the complaints process. Staff gave us examples of complaints that had led to changes in practice.
- The service was planned and delivered to meet the needs of local people. For example, accommodation was available for parents to stay on the neonatal unit and an outreach team supported the discharge process.
- The service met the individual needs of patients, including those in vulnerable circumstances. For example, there were support groups and a family care coordinator for parents on the neonatal unit.
- An electronic bed booking system had been introduced on the children's day ward to improve list utilisation.
- A paediatric flow coordinator role was introduced in April 2017. This role would support patient flow throughout the children and young people's service.
- A child and adolescent mental health service (CAMHS) was enhanced in April 2017 and was available seven days a week, meaning that children and young people suffering from mental health problems could be assessed on the same day as their admission.
- Staff described a positive and open culture with approachable and visible local leadership in the children and young people's service.
- The majority of staff demonstrated an awareness of the trust vision and values.
- Action had been taken to address some of the concerns that were identified on our last inspection. For example, additional security measures had been

introduced across the service, cytotoxic waste was now being segregated and disposed of appropriately, and a bank healthcare assistant was being used on the children's day ward.

- Senior leaders were well sighted on the risks in the division. There was a clear strategy in place for the development of services.
- There were regular governance and quality meetings within the division with good attendance from staff.
- Staff were increasingly given an opportunity to contribute to the direction and strategy of the division.

However:

- Only 16% of incidents were reported to the National Reporting and Learning System (NRLS) within 60 days.
- Checks of resuscitation equipment were inconsistent.
- Mandatory training compliance was below the trust target of 90% in February 2017. Compliance rates for medical staff (67.1%) were much lower than for nursing staff (86.9%).
- Registered nursing staffing levels regularly fell below basic levels on Buxton ward and healthcare assistants were used to increase staffing numbers when this occurred.
- There were insufficient numbers of qualified staff to fill the rota to the recommended levels for the four paediatric high dependency unit (HDU) beds on Buxton ward. In the interim, practice educators, the ward sister and staff with relevant experience but no HDU qualification were used to support the rota.
- Consultant cover in the children's assessment unit did not meet national guidance. However, consultant cover had been increased from previous levels and a CAU improvement project was underway at the time of our inspection, which included a review of the level of consultant cover.
- Cohort nursing, where infectious patients are treated together in one area away from other patients, was practiced on the children's assessment unit due to the lack of side room availability. This presented an increased risk of cross infection. However, an integrated performance report showed that daily audits were undertaken as a monitoring precaution.

# Services for children and young people

- Paediatric surgery and neonatal mortality and morbidity meeting minutes lacked detail and this limited the opportunity for shared learning with those unable to attend. It was not clear who attended meetings as only initials were recorded and the minutes for the February 2017 surgery meeting appeared to indicate that only one person was in attendance.
- The children and young people's service had lost access to four transitional beds for young people aged 16 to 18.
- There were increased admission times on the children's assessment unit (CAU) due to an increasing number of attendees with no increase in bed spaces.
- Referral to treatment time (RTT) was not met consistently across all sub-specialties, meaning that children were not always treated within 18 weeks of referral.
- Staff said that they rarely or never saw the director of nursing or the executive team.
- Staff said that there was a lack of out-of-hours management support on Buxton ward.
- The risk register did not reflect all of the risks identified on our inspection. For example, the inconsistent checks of resuscitation equipment and children being admitted onto non-paediatric wards where staff were not always appropriately trained in safeguarding or paediatric resuscitation.
- A number of the concerns identified during our previous inspection had not been addressed. For example, mandatory training compliance levels, inconsistent checks of emergency resuscitation equipment, and nursing staffing levels.

## Are services for children and young people safe?

Requires improvement 

We rated safe as requires improvement because:

- Only 16% of incidents were reported to the National Reporting and Learning System (NRLS) within 60 days.
- Checks of resuscitation equipment were inconsistent.
- Mandatory training was below the trust target of 90%. Compliance rates for medical staff (67.1%) were much lower than for nursing staff (86.9%) though there was poor safeguarding training rates for children's safeguarding.
- Registered nursing staffing levels regularly fell below basic levels on Buxton ward and healthcare assistants were used to increase staffing numbers when this occurred.
- There were insufficient numbers of qualified staff to fill the rota to the recommended levels for the four paediatric high dependency unit (HDU) beds on Buxton ward. In the interim, practice educators, the ward sister and staff with relevant experience but no HDU qualification were used to support the rota.
- Consultant cover in the children's assessment unit (CAU) did not meet national benchmarks. However, consultant cover had been increased from previous levels and a CAU improvement project was underway at the time of our inspection, which included a review of the level of consultant cover.
- Cohort nursing, where infectious patients are treated together in one area away from other patients, was practiced on the children's assessment unit due to the lack of side room availability. This presented an increased risk of cross infection. However, an integrated performance report showed that daily audits were undertaken as a monitoring precaution.
- On occasion children were admitted onto non-paediatric wards, where staff were not always appropriately trained in safeguarding or paediatric resuscitation.
- Staff stated that they had not received training in sepsis protocols.
- Paediatric surgery and neonatal mortality and morbidity meeting minutes lacked detail and this limited the opportunity for shared learning with those unable to

# Services for children and young people

attend. It was not clear who attended meetings as only initials were recorded and the minutes for the February 2017 surgery meeting appeared to indicate that only one person was in attendance.

However:

- Patient care records were clear, detailed, and contained all necessary information.
- Additional security measures had been introduced throughout the children and young people's service. All areas were found to be secure during our inspection. This addressed concerns raised during our previous inspection.
- Staff demonstrated an understanding of the incident reporting process. There was evidence of learning and communication to staff regarding outcomes of investigations.

## Incidents

- The children and young people's service had reported three serious incidents between February 2016 and January 2017. This was an increase from our previous inspection, where no incidents had been reported in a one year period. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.
- We reviewed the root cause analysis investigation reports for all three serious incidents. Two of these incidents occurred during surgery. The third serious incident was a treatment delay but this primarily related to delays in escalation by primary care rather than the hospital. The reports were all completed within the appropriate timescale. Where appropriate, the reports contained recommendations for changes to practice, with an action plan for implementation. There was evidence that learning was shared both internally and externally. For example, in one case, the case report was to be presented at the regional East Anglian Paediatric meeting and at the East of England (EoE) Paediatric Surgical Forum meeting.
- There was evidence that duty of candour had been carried out in one of the three serious incident investigation reports that we reviewed. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- The children and young people's service had reported no never events between February 2016 and January 2017. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The majority of incidents reported to the National Reporting and Learning System (NRLS) were marked as no harm or low harm. The most common incidents reported were medication (34%) and documentation (15%). Only 16% of incidents were reported to NRLS within 60 days. Incident reports should be submitted to NRLS at least monthly.
- Staff demonstrated an understanding of the incident reporting process. Staff told us that they received feedback through team meetings, emails and at handovers. Staff responsible for investigating incidents received weekly protected time to do so.
- Mortality and morbidity meetings took place in the children and young people's service. These took place separately for medicine, surgery and the neonatal unit. Minutes of these meetings confirmed that individual cases were discussed to review the provision of care in each case. Paediatric medicine mortality and morbidity meeting minutes were of a high standard; they included a detailed timeline of each case and a detailed account of the discussions held during the meeting. However, minutes for the surgical and neonatal meetings lacked this level of detail. This meant that there was limited opportunity to share learning with those unable to attend. In addition, it was not clear who attended the medical and neonatal mortality and morbidity meetings as only the initials of attendees were recorded. The minutes for the February 2017 surgery meeting appeared to indicate that only one person was in attendance.
- The service monitored and took action in response to national patient safety alerts. For example, the national patient safety alert regarding reducing the risk of hyponatraemia (low sodium level in the blood) when administering intravenous infusions to children from

# Services for children and young people

September 2007 continued to be monitored on a regular basis through its inclusion on the risk register. A local action plan had been implemented and was monitored at the medicines management meetings.

## Safety thermometer

- The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection takes place one day each month.
- Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, falls with harm or new catheter urinary tract infections, for children's services, between February 2016 and February 2017.

## Cleanliness, infection control and hygiene

- The areas inspected were visibly clean and tidy. There were sufficient quantities of personal protective equipment, such as gloves and aprons.
- Parents told us that they had observed staff regularly cleaning their hands and that the areas they visited were always visibly clean.
- There had been no cases of hospital acquired MRSA bacteraemia between April 2016 and February 2017 in the women and children's division.
- There was evidence that the service educated parents and carers on infection control practice. Parents on the neonatal unit were given a 'family guide' booklet, which included information about hand cleaning techniques. Staff were required to sign the booklet to confirm that infection control measures had been discussed with parents or carers. One parent said that staff had encouraged them to regularly clean their hands and had shown them how they could contribute towards infection control.
- The children and young people's service audited hand hygiene and dress code. The audit checked whether posters promoting hand hygiene decontamination were available and visible, whether hand sanitizer was available at the end of beds, whether there was alcohol gel inside and outside of the ward entrance, and whether there was soap in all the dispensers. Compliance scores were also given for the hand hygiene and dress code of doctors, nurses, health care

assistants, and 'other staff'. In the February 2017 audit, all checks were 100% compliant except for doctor's hand hygiene scores on the children's assessment unit, which scored 33%. However, this was re-audited one week later and compliance had increased to 100%.

- We also reviewed monthly cleaning audits. Compliance ranged between 93.6% and 97.7% for Buxton ward, the children's assessment unit and the neonatal unit between December 2016 and February 2017. Audits which scored below 95% compliance were re-audited in the same month. Compliance levels rose above 95% in all cases where re-auditing had taken place.
- Buxton ward had received a golden commode award after achieving a 100% pass rate for 12 consecutive months in the commode and bedpan audits. The children's assessment unit had also scored 100% in the commode audit in December 2016 and February 2017. However, the unit only scored 50% in January 2017.
- Quality assurance audits (QAA) carried out in November 2016 on Buxton ward and in August 2016 on the neonatal unit showed that these areas were 'compliant' regarding cleanliness and infection prevention & control. The QAA carried out in November 2016 on the children's assessment unit showed that the area was 'compliant with minor concerns'.
- Cohort nursing, where infectious patients are treated together in one area away from other patients, was practiced on occasion on the children's assessment unit (CAU). Staff said that this was due to the lack of side room availability. The risk register included an infection prevention and control risk "due to non-segregation" on the CAU. However, the integrated performance report for the women and children's division in December 2016 stated that "Cohorting of RSV (respiratory syncytial virus) patients has been ongoing. Implementation of infection control daily audits for cohort bays has been successful along with risk assessments being undertaken when non-cohort patients are admitted to the ward." Nursing dashboards for December 2016 to February 2017 show that there were no cases of hospital acquired Clostridium Difficile, MRSA or confirmed cases of Norovirus on the CAU or Buxton ward and it is therefore not clear that there had been an impact on patient safety during this time.
- Cytotoxic waste, which is waste of any kind from cytotoxic drug therapy such as chemotherapy, was segregated and disposed of appropriately on the

# Services for children and young people

children's day ward. Purple lidded sharps bins and pink labels were in use. This was an improvement from our previous inspection, where we identified that cytotoxic waste was not being dealt with appropriately.

- A grab bag containing emergency resuscitation equipment was found to be stored on the floor on Buxton ward. It is not best practice to store such equipment on the floor. This was raised with staff during our inspection, and the grab bag was moved.
- In the CQC children's survey 2014, the trust scored nine out of 10 for the question 'How clean do you think the hospital room or ward was that your child was in?' This was about the same as other trusts.

## Environment and equipment

- Daily checks of emergency resuscitation equipment were not consistent on Buxton ward and Lion ward. On Buxton ward, a grab bag of emergency equipment was only checked when it had been used. This grab bag contained intravenous (IV) fluids, which could pass their expiry date if not checked regularly. We escalated this to a senior member of staff during our inspection, who agreed that this system was not appropriate and told us that they would take action to address this. Five daily checks were missing between 4 March 2017 and 4 April 2017 from the resuscitation trolley located in the high dependency unit bay of Buxton ward. Six checks were missing between 2 March 2017 and 2 April 2017 from the resuscitation trolley located in the paediatric recovery area of Lion ward. This meant that there was not robust assurance that emergency equipment was functional and ready for immediate use.
- Inconsistencies were found in the safety checking and calibration of equipment on Buxton ward and the neonatal unit. Transport incubators on the neonatal unit should have been checked twice a day. Between 2 March and 2 April 2017, 35 checks were missing from one incubator and 25 checks from another. A senior member of staff on the unit told us that they had sent an email to all staff to remind them of the importance of regularly checking this equipment. On Buxton ward, one set of weighing scales had last been calibrated in November 2012 and another weight and height checker did not show when the last servicing or calibration checks had been carried out. This presented a patient safety risk as accurate weight measurement of children affects medication prescription and dosage.

- However, all other equipment checked was in date for safety checks and calibration. This included five items on the neonatal unit, six items on Buxton ward and six items on the children's assessment unit. Oxygen and suction equipment checked on the children's assessment unit was in working order.
- Equipment was stored in an open corridor on the children's assessment unit. This corridor was accessible to anyone in the unit. Equipment being stored included needles and syringes. There were no lockable cupboards available to store equipment.
- The children's assessment unit (CAU), children's day ward and Buxton ward were located a significant distance from the emergency department. This risk had been added to the risk register in 2013. The location meant that there was a long distance to transfer acutely unwell children from the emergency department to these areas. The re-location of CAU had also been a recommendation of a review by the Royal College of Paediatrics and Child Health. However, the relocation of the CAU was put on hold after the trust was placed under financial special measures. The risk register indicated that paediatric emergency department expansion or co-location was due to be discussed at the trust board in June 2017.
- Additional security measures had been introduced through the children and young people's service. Entries were found to be secure during our inspection and staff were observed checking the identity of visitors before allowing entry. This addressed concerns identified on our previous inspection.
- Quality assurance audits carried out in November 2016 on Buxton ward and the children's assessment unit and in August 2016 on the neonatal unit showed that these areas were 'compliant' regarding premises and equipment.
- In the CQC children's survey 2014 the trust scored 8.7 out of 10 for the question 'Did the ward where your child stayed have appropriate equipment or adaptations for your child?' This was about the same as other trusts.

## Medicines

- Buxton ward carried out weekly controlled drugs checks, whereas the children's assessment unit carried out daily controlled drugs checks. Lockable cupboards were used to store medication on the children's day ward, children's assessment unit and the neonatal unit. Medications on Buxton ward were stored in a separate

# Services for children and young people

room accessed via a swipe card. Once in the room, medications were stored in open cupboards and the drugs fridge was unlocked. Pharmacy did not carry out stock checks of medications on the children's day ward.

- An electronic prescribing system had been introduced approximately six months prior to our inspection. However, staff told us that the electronic prescribing system did not allow them to prescribe intravenous (IV) infusions and therefore paper prescribing still occurred 50% of the time. The use of two separate systems had the potential to lead to prescribing errors or duplications.
- Drugs fridge temperatures were recorded on a laminated sheet that was wiped clean every month on Buxton ward, the children's assessment unit and the neonatal unit. This meant that we were only able to check compliance for the first four days in April 2017. The neonatal unit and the children's assessment unit had both missed one check in these first four days. We were unable to check compliance with daily checks from previous months.
- On the children's day ward, the drugs fridge and the separate chemotherapy drugs fridge should have been checked daily, with the exception of weekends. Both fridges had been checked seven times in December 2016 and February 2017. Documentation for checks from January 2017 was missing. Ambient temperature checks of the drugs cupboard had been started two days prior to our inspection.
- Controlled drugs, which are prescription medications that have their usage controlled as set out in United Kingdom law, were stored appropriately and checked consistently. This was an improvement from our previous inspection, where there were concerns about the consistency of controlled drugs checks on Buxton ward.
- Ten infusion charts were checked and appropriate information, including name, date of birth, allergies, weight and signature was recorded in all but one case, where allergies had not been recorded.
- Quality assurance audits (QAA) carried out in November 2016 on the children's assessment unit and May 2016 on the neonatal unit showed that these areas were 'compliant' regarding the management of medicines. The QAA carried out in May 2016 on Buxton ward showed that they were 'outstanding' for the management of medicines.

## Records

- Twenty-one patient care records, including infusion charts and observation records, were reviewed and found to be consistently well documented, with a high level of detail.
- The electronic patient administration system (PAS) included flags on records to indicate where a child had particular needs. For example, a beach hut symbol was used to indicate child protection concerns. Staff demonstrated an awareness of this flagging system.
- Quality assurance audits (QAA) carried out in November 2016 on Buxton ward and the children's assessment unit showed that these areas were 'compliant' regarding clinical documentation. The QAA carried out on the neonatal unit in August 2016 showed that this area was 'outstanding' regarding clinical documentation.
- Staff on the children's assessment unit spoke positively about triage documentation that had been introduced on the unit since our last inspection. This documentation had red, amber and green colour coding to aid in the prioritisation of patients.

## Safeguarding

- There was a named nurse, deputy named nurse, deputy named midwife and a named doctor in the trust to lead and champion the safeguarding of children. There were also link nurses for safeguarding in the children and young people's service.
- Housekeepers and reception staff were required to complete level three safeguarding children training and all other staff were required to complete level three safeguarding children training. Staff told us that level three safeguarding children training included the topic of female genital mutilation.
- The target set by the trust for safeguarding training compliance was 90%. This had been raised from a target of 75% at the time of our previous inspection. However, this had not led to increased compliance rates.
- Level two safeguarding children training had only been completed by 54.1% of relevant staff in the children and young people's service in February 2017.
- The overall compliance rate for level three safeguarding children training in children and young people's service was 88.6% in February 2017. However, medical staff

# Services for children and young people

compliance was only 78.3%. This was significantly lower than the compliance rate for medical staff at the time of our last inspection (91%). It was also significantly lower than nursing staff compliance rate (93.5%).

- Similarly, only 62% of medical staff had completed level two safeguarding adults training, compared to 87.5% of nursing staff.
- A safeguarding report to the clinical safety sub-board in March 2017 noted that there had continued to be a significant number of children presenting with overdoses and deliberate self-harm in the period December 2016 to February 2017. Representatives from the trust were contributing to the development of local multi-agency strategies to identify and support young people who were at risk of suicide and self-harm.
- The named nurse for safeguarding had been part of the review panel for a serious case review.
- A senior member of staff told us that monthly safeguarding meetings were held in the children and young people's service.
- Safeguarding documentation audits were carried out on Buxton ward and the children's assessment unit. Ten records were reviewed in each area for each audit. Between March 2016 and March 2017, safeguarding paperwork had been completed when required in 92.9% of cases on average.
- Between October 2016 and March 2017, there were 22 admissions of children aged under 16 onto non-paediatric wards. On three of these wards, no staff had completed level three safeguarding children training. Safeguarding children and young people: roles and competences for health care staff states that "all clinical staff working with children, young people and/or their parents/ carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person" should have completed level three safeguarding children training. There was therefore a risk that staff would not be able to identify or respond appropriately to safeguarding concerns.
- Between December 2016 and February 2017, there had been 189 paediatric safeguarding referrals; an average of 63 per month.
- Safeguarding information boards and folders were available in staff areas to inform and update staff.
- The trust had an abduction policy. Three members of staff were asked about this policy and none were aware

that it existed. However, staff demonstrated that they were able to locate the policy on the staff intranet and they also demonstrated an awareness of how to respond in an abduction situation.

- Staff were in the process of developing a flow chart to support staff in deciding whether a safeguarding concern needed to be referred to the multi-agency safeguarding hub (MASH). At the time of our inspection the flow chart was awaiting approval by the safeguarding team. Once approved, it would be used across the department.
- A quality assurance audit carried out in September 2016 on Buxton ward and in January 2017 on the neonatal unit showed that these areas were 'outstanding' regarding safeguarding. The children's assessment unit was marked as 'compliant' regarding safeguarding in May 2016.
- In the children and young people's survey 2014, the trust performed in line with other trusts for questions relating to safeguarding and feeling safe in the hospital.

## Mandatory training

- The trust set a 90% target for the completion of mandatory training. This target had been raised from 85% at the time of our previous inspection in November 2015. However, this had not led to increased compliance rates.
- Mandatory training compliance was consistently better amongst nursing staff compared to medical staff in the children and young people's service. In April 2017, average medical staff compliance rate with mandatory training was 67.1%, compared to 86.9% for nursing staff. This meant that we could not be assured that all staff were trained in all mandatory aspects to ensure patients received safe care and treatment.
- Mandatory training included blood transfusion, medicines management, health record keeping, information governance, display screen equipment, equality & diversity, fire safety, health & safety, adult resuscitation, neonatal resuscitation and paediatric resuscitation.
- PREVENT training became mandatory in April 2017. The aim of PREVENT training was to raise staff awareness about the risks of radicalisation and extremism. All clinical staff were required to complete level three training, which was undertaken via a face-to-face

# Services for children and young people

workshop. Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training also became mandatory in April 2017 and staff could complete this via Elearning or face-to-face sessions.

- The neonatal unit had a mandatory training day each year, and each member of staff received protected time to attend this.

## Assessing and responding to patient risk

- Children's Early Warning Score (CEWS) and Neonatal Early Warning Tool (NEWT) systems were in use in the children and young people's services. Early warning scores are a way of monitoring patients for signs of deterioration and indicating when escalation is required. There was a trust guideline for the use of the Children's Early Warning Score and the recording of physiological observations. We reviewed seven CEWS records and five NEWT records. We found that these had been completed appropriately in all cases and that appropriate action had been taken when required.
- The completion of CEWS scores was monitored by the children and young people's service. Audit results showed that complete sets of observations were found in 91% of records reviewed for the children's assessment unit and 84% of records reviewed for Buxton ward in February 2017. Results also showed that there had been accurate allocation of CEWS scores in 91% of records reviewed in the children's assessment unit and 82% of records reviewed on Buxton ward in February 2017. The February 2017 integrated performance report for the women and children's division stated that action plans regarding the completion of CEWS were to be in place by 31 March 2017.
- Our previous inspection identified that staff in the children and young people's service did not respond appropriately to risk in patients suffering from mental health problems. A child and adolescent mental health service (CAMHS) had been introduced on 3 April 2017. Two CAMHS nurses were available at the hospital seven days a week to assess children who were suffering from mental health problems. Staff spoke positively about the introduction of this service and said that they felt able to escalate concerns to the CAMHS nurses. However, staff said that there remained a lack of support for responding to psychiatric patients.

- Junior doctors felt supported by the senior medical staff in managing deteriorating babies on the neonatal unit, and said that they were able to contact consultants at night if necessary.
- Staff stated that they had not received training in sepsis protocols, but did have access to guidelines on sepsis awareness on the intranet. Staff described the sepsis process as "very clear", and said that children with suspected sepsis were seen immediately for initial investigations to be carried out and antibiotics were prescribed within the hour.
- The children's assessment unit and the children's day ward had nurses qualified in advanced paediatric life support. The neonatal unit had nurses qualified in newborn life support.
- Children undergoing surgery were cared for by both children's and adult's nurses on Lion ward. However, adult nurses were qualified in both paediatric and adult resuscitation training.
- Between October 2016 and March 2017, there were 22 admissions of children under 16 onto non-paediatric wards. On two of these wards, there were no staff qualified in paediatric resuscitation. This meant that we could not be assured that staff would be able to respond appropriately if emergency resuscitation was required.

## Nursing staffing

- Registered nursing whole time equivalent (WTE) establishment for the children and young people's service was 171.1WTE, with an actual staffing level of 148.5. This meant that the service was 22.6 WTE posts short of the demand of the service. Senior nurses told us that recruitment had taken place for additional nursing staff; seven nurses were due to take up posts by the end of 2017 on the neonatal unit and approximately 13 nurses across the children's department.
- Acuity tools were used to set staffing levels in the children and young people's service. A senior nurse told us that the acuity tool that had previously been used was designed for the care of adults and it had been rewritten specifically for the care of children two weeks prior to our inspection. At the time of our inspection the new acuity tool was in the process of being piloted.
- There were insufficient numbers of qualified staff, due to maternity leave and sickness, to fill the rota to the recommended levels for the four paediatric high dependency unit (HDU) beds on Buxton ward. This had

# Services for children and young people

been added to the risk register in May 2016. In the interim, practice educators, the ward sister and staff with relevant experience but no HDU qualification were used to support the rota. Elective procedures that would result in post-operative HDU care were reviewed daily to ensure it could be safely accommodated. We identified no adverse incidents resulting from this temporary staffing arrangement.

- Staffing levels frequently fell below basic levels on Buxton ward. We reviewed staffing rotas for January to April 2017 and saw that most shifts were one registered nurse below basic levels. Some shifts were two registered nurses below basic levels. When registered nursing staff numbers fell below basic levels, healthcare assistants were used to increase staffing numbers. Between December 2016 and February 2016, 83.3% of registered nurse hours were filled as planned during the day, compared to 110.7% of unregistered care staff hours. At night, 81.4% of registered nurse hours were filled as planned, compared to 106.2% of unregistered care staff hours. December 2016 trust board minutes stated that “We are utilising HCAs to support ward teams when registered nurses are not available but these are not comparable on a 1:1 basis.” However, recruitment had taken place for additional nursing staff.
- Staff on Buxton ward and the children’s assessment unit raised concerns about skill mix, as there were a large number of junior nurses compared to a small number of senior nurses. Staff stated that there were occasions on Buxton ward where there was no senior member of staff on shift and this meant that the most experienced junior nurse took shift responsibility.
- Nursing staff sickness rates were 3.2% between February 2016 and January 2017, which was below the hospital average of 4%.
- The vacancy rate for registered nurses in the children and young people’s service in February 2017 was 12% on average.
- There was an average turnover rate of 12.6% for nursing staff in the children and young people’s service between March 2016 to February 2017. This was above the trust average of 11%.
- Bank usage was 3.3% on average between December 2016 and February 2017. Agency usage was 0% during this period. The trust had introduced a ‘grow the bank’ scheme, where staff would receive a pay award if they worked 75 hours of bank in a three month period over winter.

- A bank healthcare assistant had been introduced on the children’s day ward and this meant that on occasions where both nurses were performing a clinical task in the treatment room or signing for medications, there was another staff member to keep the other children on the day ward safe. This addressed concerns identified during our previous inspection. A healthcare assistant had also been added to night time staffing numbers for the children’s assessment unit. Staff spoke positively about the impact of having an additional member of staff.

## Medical staffing

- Medical staff WTE establishment for the children and young people’s service was 69.55 WTE, with an actual staffing level of 69.1. This meant that the service was 0.45 WTE posts short of the demand of the service. However, the neonatal unit was 1.55 WTE posts short of the demand for the unit.
- Locum doctors were used to cover gaps in the rota. Paediatric medical locum usage was 1% on average between December 2016 and February 2017.
- There were 26 consultants for children and young people’s services. This included six paediatric surgeons, seven paediatric anaesthetists, and seven neonatal consultants. The women and children’s division held a ‘strategy day’ in February 2017, where it was noted that paediatric consultant vacancy levels were high and recruitment was essential. It was also noted that succession planning for consultants needed to be developed.
- Consultant cover in the children’s assessment unit (CAU) did not meet national guidance. This risk was on the risk register and CAU specific consultant cover had been increased to 12pm to 9pm, Monday to Friday (42 weeks of the year), and 2pm to 8pm for 50% of weekends. However, the recommended controls on the risk register included the review of medical cover to ensure there was cover 8:30am to 10pm, 7 days a week, 52 weeks of the year, to be in line with Royal College of Paediatric and Child Health standards. Staff told us that patient rapid access consultant clinics (PRACC) were not always being covered due to the shortage in consultant cover. A CAU improvement project was underway at the time of our inspection, and this included a review of the level of consultant cover.

# Services for children and young people

- Neonatal consultants were resident on the unit between 9am and 10pm on weekdays and 9am to 7pm on weekends.
- All patients on Buxton ward were seen by a consultant every day; patients on the high dependency unit were reviewed twice a day. Buxton ward had adopted a 'consultant of the week' system, which meant that the consultant had no other clinical duties during that week so that they were fully available for the management of acute admissions.
- Medical staff said that they felt out of hours cover was sufficient.
- The medical staff sickness rate was 2.1% between February 2016 and January 2017, which was below the hospital average of 4%.
- The medical staff turnover rate between March 2016 and February 2017 was 0%. This was significantly below the trust average of 11%.
- The service was planned and delivered to meet the needs of local people. For example, accommodation was available for parents to stay on the neonatal unit and an outreach team supported the discharge process.
- A paediatric flow coordinator role was introduced in April 2017. This role would support patient flow throughout the children and young people's service.
- An electronic bed booking system had been introduced on the children's day ward to improve list utilisation.
- A child and adolescent mental health service (CAMHS) was introduced in April 2017 and was available seven days a week, meaning that children and young people suffering from mental health problems could be assessed on the same day as their admission. Staff had recognised the need for increased provision of the service.
- The service met the individual needs of patients, including those in vulnerable circumstances. For example, there were support groups and a family care coordinator for parents on the neonatal unit.
- Staff across the children and young people's service were knowledgeable about the complaints process. Staff gave us examples of complaints that had led to changes in practice.

## Major incident awareness and training

- There was a trust-wide major incident response plan. This included specific plans for the care of children involved in a major incident.
- Senior nursing staff on the children's assessment unit told us that they had attended Majax major incident training alongside senior nursing staff from Buxton ward since our previous inspection.
- The trust was providing once monthly major incident training sessions between April and June 2017; this would cover an introduction to emergencies and major incidents.
- Staff told us that a live major incident practice scenario was due to take place in October 2017, where the security system would be tested. We were informed that no live practice scenarios had previously taken place in the children and young people's service.

However:

- The children and young people's service had lost access to four transitional beds for young people aged 16 to 18.
- There were increased admission times on the children's assessment unit (CAU) due to an increasing number of attendees with no increase in bed spaces. This risk had been on the risk register since 2011.
- Referral to treatment time (RTT) was not met consistently across all sub-specialties, meaning that children were not always treated within 18 weeks of referral.

## Are services for children and young people responsive?

Good



We rated responsive as good because:

## Service planning and delivery to meet the needs of local people

- Recreation facilities were age appropriate for the range of children using the children and young people's service. There were rooms for both children and adolescents on Buxton ward. The playroom had play equipment for younger children, and the adolescent room had facilities such as a game console, computer tablet, and board games for older children. The waiting area in the children's outpatients department and children's day ward had a range of toys, books and

# Services for children and young people

games to entertain children of all ages whilst they waited to be seen. Buxton ward had a parents' room and could provide a bed and bed linen for one parent, carer or other family member per child, for use next to the child or young person's bed. Patients on Buxton ward had access to individual televisions which were free to use. Teachers were available on Buxton Ward for four afternoons and one morning each week during term time. There was also an e-learning programme via laptops.

- A sitting room with a kitchen and television was available for parents and visitors on the neonatal unit, as well as a sibling's play area. There was accommodation for parents to spend the night when their babies required intensive care. One parent told us that staff had encouraged them to make use of this accommodation in preparation for taking their baby home.
- A nurse-led neonatal outreach team worked in the community to facilitate early discharge and provide support to those that had been discharged from the unit. Parents and babies were supported with naso-gastric tube feeding, home oxygen, and stoma care.
- There was a forum for families of children with complex needs. This forum was led by nurses and had access to a complex needs steering group which shaped the service.
- Between October 2016 and March 2017, there were 22 admissions of children under 16 onto non-paediatric wards. These admissions were to areas where nurses trained to deliver care to adults were providing care to children and young people. This meant that the specific needs of children and young people might not have been met.
- On our previous inspection, the children and young people's service had four transition beds on Cringleford ward for adolescents aged 16 to 18 years. However, pressure on beds trust-wide meant that the children and young people's service had lost access to these beds. The CQC self-assessment document completed by divisional leaders in April 2017 acknowledged that this meant transition experiences were less easy to optimise.
- The trust performed about the same as other trusts for all of the four questions relating to responsiveness in the CQC children's survey 2014.

- Patients have the right to be treated within 18 weeks of being referred for treatment (RTT). A target of 92% was set for patients to receive inpatient treatment within 18 weeks. Incomplete performance was 90.4% on average between December 2016 and February 2017. However, there were sub-specialties with much lower compliance. For example, paediatric ear, nose and throat compliance was 70.95% and paediatric respiratory medicine compliance was 69.86% in December 2016.
- In February 2017, 91.7% of non-admitted paediatric patients received treatment within 18 weeks. This had increased from 90% between November 2016 and January 2017. However, there were sub-specialties which had much lower compliance. For example, paediatric respiratory 18 week compliance was at 71.2% in December 2016 and paediatric ear nose and throat compliance was 71% in December 2016.
- Action was being taken to address referral to treatment times. Additional capacity was being sought to provide ad-hoc clinics through existing medical staff. Multi-disciplinary team pathway reviews were being set up for paediatric respiratory and paediatric neurology. A 'strategy day' held by the women and children's division in February 2017 identified "achievement of 92% against 18 week target as a minimum for paediatric patients" as a long-term ambition.
- Patients have a right to be seen by a cancer specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected. Between December 2016 and February 2017, this was achieved in 94.4% of cases for the children and young people's service. Patients have a right to a maximum 31-day wait for subsequent treatment where the treatment is surgery; this was being achieved in 100% of cases between December 2016 and February 2017.
- There were no cancelled operations for the children and young people's service between December 2016 and February 2017.
- A new paediatric flow coordinator role was due to be introduced in the children and young people's service in April 2017. This role would support patient flow throughout the children and young people's service. Staff told us that this role would focus on discharges and identify any blockages in the flow of patients. The role had initially been recruited as a six month secondment. Staff spoke positively about the introduction of this new role.

## Access and flow

# Services for children and young people

- Staff told us that cancellations and patients who did not attend (DNA) were flagged and monitored in the children's outpatients department.
  - An electronic bed booking system had been introduced on the children's day ward to improve list utilisation. Staff from other areas in the children and young people's service were able to access this system and this promoted the sharing of bed availability.
  - Staff also had access to a computer system which allowed them to check the number and type of patients that were in the emergency department. This allowed them to anticipate admissions to the children and young people's service.
  - Between December 2015 and November 2016, there were 8937 emergency admissions and 814 elective admissions.
  - Admissions to children's assessment unit could be from either the emergency department, GPs, specialist teams, midwives, community teams or from home when children with long-term conditions had open access to the trust. Admissions to the children's day ward were elective, with children attending from home. Admissions to Buxton ward were either elective admissions booked by the waiting list coordinator; emergency admissions received from the children's assessment unit; emergency admissions from the emergency department if the child did not require assessment on CAU first; transfers from other trusts; or open access patients. Buxton ward were limited to accepting eight surgical patients each day.
  - Staff said that the child and adolescent mental health service (CAMHS), introduced on 3 April 2017, would reduce admission times as it ensured that children suffering from mental health problems would be assessed by the CAMHS team on the same day as admission. Before the introduction of the CAMHS service, children admitted over the weekend waited until Monday for an assessment.
  - The children's assessment unit (CAU) was seeing an increasing number of attendees from a wide range of referral routes with no increase in bed spaces. This had led to increased admission times. Staff told us that there were occasions where patients had remained in the unit for over 24 hours. This risk had been identified and added to the risk register in November 2011. A CAU improvement project was underway at the time of our inspection, which would involve reviewing the pathway for CAU.
  - The parent of a patient who attended the service on a regular basis said that they had experienced treatment delays on occasion. However, they also said that the physiotherapist would come to see their child when they were on the ward to avoid the need for an additional outpatient appointment.
- ## Meeting people's individual needs
- Translation services were available within the children and young people's service via a telephone service. Translators could also be arranged to attend the ward when necessary. The majority of staff showed an awareness that the use of family members for translation was not best practice. However, a senior nurse said that an internet search engine would be used as a 'stop gap' when necessary. It was recognised that this was not ideal and they would ensure that a translator was arranged to follow up the next day.
  - Information booklets specifically designed for families of neonatal babies were available in the neonatal unit. These provided parents with information about the unit, including visiting times, facilities for parents, frequently asked questions, and support groups. The booklet also contained diary sheets for parents and staff to complete. There were competencies on carer administration of medicines and nasogastric tube feeding, as well as a set of 'education skills for parents', which both parents and staff signed to indicate completion.
  - Communication diaries were used on Buxton ward to document patients' care and progress. The diary was designed to be filled out by both parents and staff. Staff said that this was particularly useful for parents who did not live near to the hospital, and helped parents feel more involved in their child's care. One member of staff gave an example of how this diary had been used successfully for a child whose parents were separated and had previously not felt able to communicate with one another about their child's care.
  - Two learning disabilities nurses were available in the trust, who provided advice, support and training. Staff in the children and young people's service were aware of the learning disabilities nurses and spoke positively about their roles. Learning disabilities folders and boxes were available for staff to use, which included communication aids.
  - Buxton ward had a number of link nurse roles for staff on the ward. This included a learning disabilities link nurse and a mental health link nurse.

# Services for children and young people

- Buxton ward had named nurses for complex patients. Named nurses had an awareness of the overall plan for the patient and linked the nursing and medical team with the child's parents.
- Buxton ward had received funding to turn part of what was currently the adolescent room into a sensory room for children with sensory disabilities. This would include installing black out blinds and sensory lights.
- The parent of a patient with a rare long term condition on Buxton ward said that staff had worked with them to learn more about the condition.
- A hoist was available on Buxton ward, which could also weigh children who were unable to stand or sit on scales. This hoist could be accessed by other areas, such as the children's day ward, when required.
- The outpatients department had wide entryways to allow access for wheelchair users.
- Staff had access to four play therapists, who could help children cope with the pain, anxiety or fear they might experience during their time in hospital. One parent said that a play therapist had helped their child get through a difficult procedure. However, play therapists were only available Monday to Friday.
- A patient passport, which had been designed by staff at the trust, had recently been introduced for children or young people with learning disabilities. Patient passports contain important information about a patient, including likes and dislikes.
- Staff in the outpatients department said that they would try to arrange appointments for children with learning disabilities at the start of a clinic and there was a smaller and quieter waiting area that could be used if required.
- The neonatal unit ran a kangaroo group, which gave parents the opportunity to learn how to care for their baby and help prepare to take their baby home. The group included sessions on breast feeding, making up feeds, giving medication, safer sleeping, resuscitation training, positive touch and baby massage. Parents confirmed that they had been informed about the group and those that attended said that they had found the group useful and informative.
- A Bliss family care coordinator worked in the neonatal unit and was available to support parents, answer questions and offer advice. Bliss is a UK charity working to provide the best possible care and support for all premature and sick babies and their families.
- A senior nurse told us that the neonatal unit had access to three cuddle cots. Cuddle cots contain a cooling pad

- and are used to allow recently bereaved parents to spend time with their baby. Staff gave examples of parents who had been able to spend three or four days at home with their baby.
- The neonatal unit worked with a number of charities in the provision of end of life care. This included memory boxes donated by the 4Louis charity and bereavement support through close links with the SANDS charity. The unit had recently begun working with a charity which provided bereaved parents with a free of charge disc of professional photos of their baby. The hospital bereavement team provided support to parents on the neonatal unit. Staff said that bereaved parents were able to return to visit the unit as often as they wished.
  - On Buxton ward, staff worked closely with the hospice when patients wished to remain on the ward at the end of their life.

## Learning from complaints and concerns

- Between 1 January 2016 and 31 January 2017 there had been 35 complaints raised across the children and young people's service. This was a significant increase from our previous inspection, where five complaints had been raised in a one year period. However, 35 complaints equates to 0.4% of hospital admissions to the children and young people's service and therefore complaints remained low in comparison to overall activity. We reviewed the complaints that were received between January 2016 and January 2017; the most common complaint categories were clinical treatment, appointments delays/cancellations, and communications.
- None of the parents or carers spoken to on inspection had made a complaint. However, they knew how to complain and felt able to do so. One parent told us that the reason they had not needed to make a complaint was because staff had dealt appropriately with an incident that had occurred during their child's stay in hospital. They said that there had been daily follow-up from staff about the incident.
- Staff from all areas of the children's and young people's service stated they would attempt to resolve complaints informally in the first instance and they gave examples of when they had done so. Leaflets for the Patient Advice and Liaison Service (PALS) were available in all areas of the service and staff said that they gave these to patients and carers who raised a concern or complaint. The trust had also produced leaflets called 'help us to

# Services for children and young people

help you', which patients and carers could fill out to rate their experience, provide suggestions, comments, compliments or to make a complaint. These leaflets were available in all areas in the children and young people's service.

- Feedback and outcomes from complaints and compliments were communicated to staff across all of the children and young people's service via emails, team meetings and handovers.
- All staff asked about complaints on the neonatal unit told us that 'communication' had been identified as a theme in the complaints received for the unit. This demonstrated that complaints had been discussed on the unit and staff said that they had focused on making improvements in this area as a result.
- On Buxton ward, a complaint had been made about the incorrect management of a child's pain. As a result, staff on the ward had liaised with the pain team to organise further training for all senior staff, a second check was introduced for all patient controlled analgesia (PCAs) and a bespoke teaching session was organised for a nurse.
- On the neonatal unit, parents had complained that they were not able to stay with their baby whilst ward rounds took place. Staff were concerned about patient confidentiality if parents remained during ward rounds, as they may have been able to overhear the details of another child's care. Staff on the unit spoke to members of the East of England neonatal operational delivery network to understand practice on other neonatal units. As a result, headphones had been introduced for parents' use during the ward round, which allowed them to remain with their baby.
- Quality assurance audits (QAA) carried out in September 2016 on Buxton ward and in May 2015 on the children's assessment unit found that they were compliant regarding complaints. The QAA carried out on the neonatal unit in January 2017 marked the unit as outstanding regarding complaints.

## Are services for children and young people well-led?

Good



We rated well-led as Good because:

- Staff described a positive and open culture with approachable and visible local leadership in the children and young people's service.
- The majority of staff demonstrated an awareness of the trust vision and values.
- Senior leaders were well sighted on the risks in the division. There was a clear strategy in place for the development of services.
- There were regular governance and quality meetings within the division with good attendance from staff.
- Staff were increasingly given an opportunity to contribute to the direction and strategy of the division.

However:

- Staff awareness of the departmental strategy was limited.
- Staff said that there was a lack of out-of-hours management support on Buxton ward.
- The risk register did not reflect all of the risks identified on our inspection. For example, the inconsistent checks of resuscitation equipment and children being admitted onto non-paediatric wards where staff were not always appropriately trained in safeguarding or paediatric resuscitation.
- Staff said that they rarely or never saw members of the executive team.

### Leadership of service

- The children and young people's service was part of the women and children's division and was led by a divisional nursing director, a medical chief of division and a divisional operations manager.
- Staff told us that matrons and the divisional leaders were visible but that they rarely or never saw members of the executive team.
- Staff said that their ward managers and matrons were approachable and supportive. For example, one member of staff told us that their matron carried a phone so that staff could contact them when necessary. Staff described times when they had experienced family emergencies or other personal problems and their leaders had been supportive and worked with them to re-arrange their shifts or arrange time off work.
- Nurses in charge were experienced and capable of leading their teams.
- Staff on Buxton ward told us that there was a lack of management support on evenings and weekends. Staff described a nine to five, Monday to Friday culture. As a

# Services for children and young people

result, nurses that were not at management level were often shift responsible and involved in patient allocation. The Trust told us there was a senior paediatric nurse on duty carrying a bleep and also support from the site team.

## Vision and strategy for this service

- The majority of staff in the children and young people's service demonstrated an awareness of the trust vision and values. The trust vision was 'to provide every patient with the care we want for those we love the most'. The trust values were PRIDE: people-focused, respect, integrity, dedication and excellence.
- Senior leaders of the division had a clear vision and strategy. Whilst the division was a comparatively new structure, they told us that it was functioning well. There were advanced plans to increase the presence of the specialist children's staff into areas that had previously not had this support such as outpatients. There had also been the successful recruitment of over twenty registered nurses (child branch) for the division.
- The strategy for the children and young people's service had objectives which focused on adolescents and young people making the transition from children's to adult's care, the development of services with specialist teams, participation in clinical research and improved partnership working with tertiary services and mental health care providers. The women and children's division had held a 'strategy day' in February 2017, where challenges, opportunities, aims for each sub-speciality and long term ambitions were identified.
- Staff awareness of the departmental strategy was limited. For example, one member of staff said that the strategy was "to provide excellent care and prevent errors". A number of staff spoke about the trust values and vision when asked about the strategy. However, when prompted, the majority of staff showed some awareness of the future plans for their ward or unit. Staff spoke about the introduction of an electronic bed booking diary on the children's day ward, increasing the number of sessions in the children's outpatients department and a pathway review that was underway in the children's assessment unit.

## Governance, risk management and quality measurement

- There were individual governance meetings for children's medical, surgical and neonatal care. These

- meetings provided an escalation pathway to an overall children's services governance meeting. For example, the neonatal governance meeting minutes included "areas to highlight in overarching paediatric governance meeting" and "key areas for escalation to divisional board". This meeting provided a pathway into a divisional women's and children's governance meeting.
- Women and children's division board meetings were held on a monthly basis with key staff, including divisional leaders, matrons, and lead nurses. These meetings covered caring & patient experience, clinical safety, clinical effectiveness, and performance.
- A children's board meeting was held in February 2017 to monitor standards and governance of paediatric care across the organisation.
- A senior nurse told us that matrons and divisional governance leads held weekly meetings to discuss and review incidents. There was a quarterly risk newsletter circulated within the children and young people's service that highlighted any learning and improvements to practice from any incidents and complaints.
- Performance was monitored in the women and children's division through monthly integrated performance reports. These included information about risks, complaints, incidents, audit results, workforce information.
- Performance was also monitored through monthly nursing dashboards. These included results from quality assurance audits, training compliance rates, complaints and incidents, infection rates, and audit results. A red, amber, green (RAG) rating system was used to indicate whether targets were being met, with green indicating compliance and amber and red indicating non-compliance.
- The management of risks on the children and young people's service risk register was good. Initial scoring based on consequence and likelihood were given to described risks. Controls, assurances and ongoing monitoring of actions were recorded with clear review dates.
- There were five risks linked to the paediatric directorate on the trust's risk register. One of the five risks had been added since the date of our last inspection and this related to staffing levels for the four paediatric high dependency unit beds on Buxton ward. However, the risk register did not reflect all of the risks identified on this inspection. For example, the inconsistent checks of

# Services for children and young people

resuscitation equipment and children being admitted onto non-paediatric wards where staff were not always appropriately trained in safeguarding or paediatric resuscitation.

## Culture within the service

- There was a positive culture throughout the children and young people's service. Staff said they felt well respected and valued by their teams and their leaders. None of the staff spoken to during inspection raised concerns about bullying or intimidation.
- Staff described an open culture and said that they felt able to raise concerns when necessary. The trust had introduced six Freedom to Speak Up Guardians, who were also staff governors, who provided an additional point of contact for staff to seek advice on how to deal with a concern. Staff in the children and young people's service were aware of the Freedom to Speak Up Guardians.
- Staff told us that the wards and units in the children and young people's service worked together to share resources when there were staffing shortages.
- Trainee doctors spoke positively about the level of support they received.
- Two senior nurses felt that children's services were not high on the agenda at the trust. The 'strategy day' held by the women and children's division in February 2017 identified one of the long-term ambitions for the paediatric service as a "loud and recognised "paediatric voice" across trust".

## Public engagement

- An updated children's playground was unveiled in July 2016. Children were given the opportunity to give ideas for the playground and these were incorporated into the final design.
- The children's diabetes team ran an annual insulin pump and blood glucose meter fair, which provided information to children and their parents or carers.
- The annual patient choice award gave patients the opportunity to nominate a health professional or hospital team that had gone the extra mile in providing their care. The paediatric diabetes team was nominated for and won the patient choice team of the year award in 2016.

- The trust held winter and summer fetes, which included behind the scene tours and gave children the opportunity to take their teddy for an x-ray. This helped patients understand more about the service.
- A family forum had been set up for families of children with complex needs; this provided an opportunity for families to provide feedback and contribute towards shaping the service.

## Staff engagement

- Staff were given the opportunity to contribute when changes were being implemented in the children and young people's service. For example, during the CAU improvement project, meetings were held with consultants and the wider multi-disciplinary team as well as a nurse-only focus group to identify improvements.
- A monthly staff award had been set up on the neonatal unit. This gave staff the opportunity to nominate a colleague who they felt had gone the extra mile. Monthly award winners were displayed in the staff room with a photo and the reason for their nomination.
- Staff said that they felt engaged through regular meetings, where they were encouraged to provide feedback. Staff received regular update emails from the chief executive, director of nursing, and matrons. Staff said that the senior leadership team held open forums on a regular basis.

## Innovation, improvement and sustainability

- The service had recognised the need to expand or relocate the CAU for future sustainability but this was put on hold after the trust was placed under financial special measures. However, an improvement project was underway at the time of our inspection to review the pathway and consultant cover for CAU.
- The children and young people's service was proactive in clinical research. There were a large number of active research studies being undertaken throughout the children and young people's service. This meant that the service was at the forefront of clinical innovation.

# Outstanding practice and areas for improvement

## Outstanding practice

- The children and young people's service was proactive in clinical research. There were a large number of active research studies being undertaken throughout the children and young people's service. This meant that the service was at the forefront of clinical innovation.
- The hospital received funding January 2017 following a successful bid to the Department of Health's Maternity Innovation Fund and the Maternity Safety Training Fund to provide additional training for staff. The Maternity Innovation Funding was for a new piece of simulation technology called 'CTGi' which replicates a baby's heart rate pattern during labour. This piece of training technology will be used within clinical areas for both the midwifery and medical teams and supplement more traditional class room tutorials and e-learning programs.
- The trust was about to launch the 'Baby University' scheme. Every new or expectant mum that signs up for the scheme will receive a Baby Box made from a very thick cardboard, a firm foam mattress, waterproof mattress cover and a cotton sheet. The scheme replaces the need for a traditional Moses basket or cot, and it is thought the small size of the Baby Box helps to prevent sudden infant death syndrome.
- Cley gynaecology ward had a bereavement baby memento bag/box for parents, which contained a form to acknowledge the existence of a foetus born before it was viable (as a birth certificate could not be issued) and tiny hand knitted garments for stillborn babies to have photographs for parents.

## Areas for improvement

### Action the hospital MUST take to improve

#### Action the hospital MUST take to improve

- The trust must ensure that medication is stored in line with trust policy and that staff record medication refrigeration temperatures to ensure the safe storage of refrigerated medication.
- The trust must ensure that resuscitation equipment in wards, theatres and other areas is checked in accordance with trust policy.
- The trust must ensure that patient records are stored securely.
- The provider must ensure staff complete appropriate mandatory training including safeguarding training to an level appropriate to their job role.

### Action the hospital SHOULD take to improve

- Ensure that there are adequate medical and nursing staff and an appropriate skill mix to care for patients in line with national guidance.
- The provider should ensure they regularly undertake observational audits or measurement of the quality of the World Health Organisation (WHO) five steps to safer surgery checklists and action any lessons learnt.

- The trust should ensure it meets the referral to treatment time for specialities that do not meet the England average such as gynaecology.
- Ensure staff follow infection prevention and control procedures and do not leave side room doors open when they should be kept closed to minimise the spread of infection.
- The trust should ensure that maternity electronic discharge information is sent to general practitioners within 24 hours of discharge.
- The trust should consider how they provide community midwives with access to information technology.
- Review access to transitional beds for young people aged 16 to 18.
- Ensure clinical staff receive training in sepsis protocols and procedures.
- Ensure that staff caring for children in non-paediatric areas have appropriate safeguarding and resuscitation training.
- Ensure morbidity and mortality meeting minutes include sufficient detail of background information, discussions and those in attendance.

# Outstanding practice and areas for improvement

- Review the children's assessment unit to address admission times, infection control concerns, and distance to transfer acutely unwell children from the emergency department.
- The trust should ensure that it contributes to the national Maternity Safety Thermometer.
- Review and ensure the effective management of community midwifery staff.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

#### Regulated activity

Diagnostic and screening procedures  
Treatment of disease, disorder or injury

#### Regulation

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

The provider was failing to ensure that medicines were stored correctly in line with trust policy or that fridge temperatures were checked regularly.

The provider was failing to ensure that emergency equipment including resuscitation equipment was checked regularly in line with trust policy.

The provider was failing to ensure that staff received mandatory training including safeguarding training. .

#### Regulated activity

Diagnostic and screening procedures  
Treatment of disease, disorder or injury

#### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider was failing to ensure that patient records were stored securely to protect confidentiality.