This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

**Facts and data about this trust**

Norfolk and Norwich University Hospitals NHS Foundation Trust operates primarily across two sites:

- Norfolk and Norwich University Hospital (NNUH) – this was built in 2001 and is based on the Norwich Research Park. Care is provided for a tertiary catchment area from Norfolk and neighbouring counties across the sustainability and transformation partnership (STP)
- Cromer and District Hospital – this was rebuilt by the Trust in 2013. It has a minor injuries unit and provides a range of outpatient and day-case services

The trust has made significant investments in additional capacity, which includes additional inpatient facilities, four new interventional radiology laboratories and a fourth cardiac catheter laboratory which are due to open in Spring 2020. The Trust also recently opened a new positron emission tomography computed tomography (PET CT) scanner. At Cromer hospital, a new ambulatory cancer centre is planned to open in 2021 in partnership with Macmillan cancer.

The trust opened the Quadram Institute in December 2018 in research partnership. This houses the largest endoscopy unit in Europe and research facilities, providing teaching and clinical training to a wide range of health professionals in partnership with the University of East Anglia and the Norwich Medical School. The trust also hosts the National Institute for Health Research (NIHR) clinical research network for the Eastern region.

The trust is involved in partnership working across the healthcare system, including joint clinical appointments with neighbouring trusts, a shared electronic prescribing system, an STP wide urgent and emergency care delivery board and a referral to treatment (RTT) management board which works across the system to support delivery against key targets.
The trust has also embarked upon an STP sponsored programme to redesign acute service provision across three acute hospital sites. This work will result in NNUH becoming the lead provider for a range of services across the county.

(Source: Routine Provider Information Request (RPIR) – Acute context tab)

Hospital sites at the trust

A list of the hospitals at Norfolk and Norwich University Hospitals NHS Foundation Trust is below.

<table>
<thead>
<tr>
<th>Name of hospital site</th>
<th>Address</th>
<th>Details of any specialist services provided at the site</th>
<th>Geographical area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk and Norwich University Hospital</td>
<td>Colney Lane, Norwich, NR4 7UY</td>
<td>Day procedure unit, Dermatology, ENT/Oral health, General surgery, Ophthalmology, Oral surgery, Plastic surgery, Urology, Trauma and orthopaedics, Vascular</td>
<td>Norfolk</td>
</tr>
<tr>
<td>Cromer Hospital</td>
<td>Mill Road, Cromer, NR27 0BQ</td>
<td>Day procedure unit, General surgery, Ophthalmology</td>
<td>Norfolk</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Sites tab)

Is this organisation well-led?

Leadership

Board Members

Of the executive board members at the trust, none were Black and minority ethnic (BME) and 33.3% were female.

Of the non-executive board members none were BME and 28.6% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0.0%</td>
<td>33.3%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>0.0%</td>
<td>28.6%</td>
</tr>
<tr>
<td>All board members</td>
<td>0.0%</td>
<td>30.8%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Board Diversity tab)

There had been significant changes in the executive leadership team in the preceding 18 months. There was a strong clinical voice and a more cohesive approach from operational and clinical perspectives. Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. However, the senior teams were still coalescing to become a highly productive team. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
The trust leadership were relatively new as a group of directors with almost all executive directors joining the trust in the last year, although all had executive experience. The Chief Nurse and the Medical Director had been in post since 2018. However, the Medical Director and the Chief Operating Officer had been at the trust in different posts for some time. The chief executive was appointed in October 2019 shortly before our inspection and was appointed initially on a fixed term contract with a planned review of performance after six months. It was anticipated that following a satisfactory assessment a permanent appointment would be made. The director of finance was shortly to retire leaving an important vacancy on the board. Since our last inspection there was also the appointment of a new chairperson of the trust who had significant experience as chair at another NHS trust. There were also four non-executive directors appointed since our previous inspection. Therefore, the board whilst being substantively appointed to were still in the early phases of becoming an established team. The trust had commissioned a board development programme in order to ensure that the board functioned to the best of its ability.

Collectively, leaders demonstrated a complementary set of skills with which to address some long-standing issues at the trust. There was good insight into the ongoing development the board needed, and the board development programme continued throughout 2019. Each director spoke of a stronger sense of a unitary board; we found executives were clear about and understood the trust’s journey and direction of travel. Communication between board members as well as non-executive directors (NEDs), both formally and informally, was open, transparent and with constructive challenge. However, there remained some concerns that having a significant number of new NEDs in post could impact upon the challenge to the board. This risk was mitigated in part by the appointment of one NED who had NHS board level experience and a number of NEDs who had board level experience in other organisations. There had been a move to strengthen the clinical focus of the NEDs. Whilst these mitigations are in place the chair of the trust remains conscious that the new NEDs require extra support to fully develop into their roles.

The chair of the trust felt that the tone of the board set the tone of the organisation and was clear of the importance on improving and developing relationships within the organisation and with other stakeholders. The board maintain a clear timetable of events to encourage cohesiveness as well as improve visibility, quality and operational management of the trust. Executive directors told us these initiatives had been positive for them as a group and also the wider trust. Staff we spoke told us of an increased visibility of executives and an ‘open door policy’ in the executive offices. Board ward clinical and departmental visits had been introduced prior to board meetings that involved both executive directors and NEDs. This had increased visibility of senior leaders in the organisation as well.

There was a board development plan in place. This was to support the relatively newly formed board work in a cohesive way, develop their skills and demonstrate accountability for the services. The development plan was being reviewed at the time of our inspection.

All senior staff, as well as more junior staff, we spoke to on the core services inspection spoke positively about the senior leadership team including the increased clinical voice in the organisation. Whilst some staff continued to feel frustrated about the pressure the service was under, they told us that they felt listened to by the senior leaders which was an improvement on previous inspections.

Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 states that providers must take proper steps to ensure that their directors, or equivalent, are fit and proper for the role (FPPR). It applies to a provider’s board directors, board members and equivalents, who are responsible and accountable for delivering care, including associate directors and any other individuals who are members of the board, irrespective of their voting rights.
The trust had an FPPR policy in place to support the process of appointing senior managers. We reviewed four personnel files of executive directors, including those most recently appointed. We found that the improvements we had found before had been maintained in the management of FPPR, recruitment and line management of the executive team. Most files were complete with records of the recruitment process, interview notes and references though in one file there were no interview notes. The trust informed us that interview notes were kept separately to personal files. Disclosure and Baring Service (DBS) checks had been properly completed. There were annual ongoing checks including a search of disqualified directors and bankruptcy which were all completed in the files we reviewed.

The divisional management structure had been introduced in April 2016 and at previous inspections we had found they were not always supported to make decisions about their services. We spoke with the divisional triumvirates of clinical leaders (a chief of division, divisional operations director and divisional nursing director) at our core services inspection as well as our well led inspection. We found that the divisional teams had matured. They were well sighted on their risks and had clear plans to address them and ensure mitigation. The governance throughout the divisions had been improved by the appointment of a governance manager to work with the triumvirates. All the divisional staff we spoke with told us that they were increasingly supported in their roles and to make clinical and operational decisions for the benefit of patients. The divisions had been supported in their development by senior managers as well as through away days and development programmes.

We met with the lead governor and three other governors. There was a mix of existing governors and new governors. The governors were aligned to areas within Norfolk and surrounds and brought the issues of their communities to the trust. All the governors we met had links with other health organisations. This added the benefit that they understood the patient pathway from primary to secondary care.

The governors spoke highly of the executive team and the chair. They understood the changes that the new leadership wanted to bring to their role. The chair had discussed with the governors sitting on committees and whilst being able to input into the discussions they would not have voting rights. This meant that the governors would be able to provide a lay perspective on the issues discussed. The governors welcomed these changes and looked forward to having a greater impact upon the management of the trust. There was recognition that these changes would mean that the governors would benefit from additional support.

The governors had been involved with the shortlisting and the appointment of non-executive directors and chair and felt supported in this process. The governors told us about the improvement in engagement with staff in the organisation. They felt that the Freedom to Speak Up Guardian was important in improving the confidence of staff to speak up. Quality rounds involving governors had been reinstated under the new chair and were now happening regularly. Whilst the work with the governors was still in its infancy there remained a risk to the oversight and challenge given at board level.

The senior team at both board and divisional level were cognisant of the previous challenges that the trust had had in terms of ensuring a compassionate, inclusive and effective leadership. Whilst some of the leadership team had not been at the trust when these issues had been highlighted there was a recognition that to take the trust forward this leadership team needed to engage with staff at all levels through listening events and seeking the views of staff to solve the challenges individual departments faced. Whilst work had continued on shifting this culture since our previous inspection there was a recognition that this would take some time to completely resolve. However, we saw areas where there was some significant improvement. The trust had delivered a trust wide programme called Rudeness Costs Lives during 2019 which sought to demonstrate the impact of poor behaviours at all levels.
Vision and strategy

The trust had a clear vision and set of values. The trust's strategy was due for renewal. Staff knew the trust corporate vision and values. Divisional vision were aligned to that of the trust objectives.

The trust vision, values and objectives remained the same as at previous inspections with the vision being “To provide every patient with the care we want for those we love the most”. The five values supporting the vision were people focused, respect, integrity, dedication and excellence.

The corporate strategy, originally approved in 2016 and updated in 2017 was still in place but was due for renewal.

The four objectives to the strategy were:
1) We will be a provider of high quality health and care services to our local population;
2) We will be the centre for complex and specialist medicine for Norfolk and the Anglia region;
3) We will be a centre of excellence for research, education and innovation
4) We will be a leader in redesign and delivery of health and social care services in Norfolk.

The trust had made progress in developing a new strategy and were clear of the input required from staff, stakeholders, patients and the public.

At the time of the inspection there was a clear focus on developing additional capacity to manage the increasing demand on the trust's services. It was clear at this inspection that the trust remained under intense pressure which impacted on the services it was able to deliver, for example in the day procedure unit. The trust were in the process of adding additional capacity to the trust. This would result in an additional 100 inpatient beds that were to be in place by February 2020. The new interventional radiology unit was also due to open in spring 2020 which would add significant extra capacity to the service. Executives we spoke with told us that the bed base at the trust was not in line with the demands the trust faced or the wider strategy of the Norfolk and Waveney Sustainability and Transformation Plan (STP) and the development of services in Norfolk. This had led to the investment in creating additional capacity.

The new strategy was being developed in line with expectations and plans in the STP as well as those of the trust. The trust was four years into a five year strategic plan and actively working to scope and develop the new strategy. The trust was also engaging with system partners, acute, community and mental health trusts to develop a strategy that met the needs of the people of Norfolk and further afield. There was already integrated working with other trusts in the development of specialist pathways in urology and other services. It was clear from talking to executives that an evolving new strategy would put patients at the heart of services and to do so in a sustainable way.

The current corporate strategy was monitored by the board. We had previously been told that the delivery of the strategy had been impacted by a number of factors including financial and quality special measures and finance. At this inspection we were told that the new strategy was looking beyond these difficulties, whilst not downplaying the impact they had clearly had on them organisation. There was a clear focus on quality and safety aimed at providing the best possible care as well as aiming to be removed from quality special measures.
There was a shared vision between the chair and the chief executive to enable local people to access high quality care in a cost effective way. They were clear this could only be achieved with support and cooperation within the STP and with neighbouring STP’s. It was clear that senior executives were focussed on patients and putting them at the heart of all decision making.

Culture

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

At previous inspections we found there to be significant concerns about the culture within the organisation. At this inspection we found that the continued cultural work had had a positive impact in the majority of areas however, there were still pockets of poor culture in some areas. The trust had taken a number of steps to continue to embed a positive culture in the organisation. In addition to previous work as outlined in previous reports the trust had continued organisational development work including ‘Rudeness costs lives’. This training programme, based on research, was delivered throughout 2019. It was aimed at all staff and was to promote greater civility, particularly when work got pressurised. The trust had identified that concerns about behaviours and communication in the past had occurred when staff were under significant pressure with this programme aimed to address this. Staff we spoke with talked positively about this and that it was having an impact with more work to do. There were also other interventions including the use of an external company to engage in interventions with leaders in the organisation to support conversations and cultural work in the organisation.

The trust had reinstated the PRIDE awards. These were aligned with trust core values. The staff committee were involved with the assessment for the awards, so it is peer based. Staff committee get involved in assessment. There had been no awards given for two years despite a backlog of awards agreed that were never presented. This has now been rectified. No awards for 2 years so backlog approved but never got them. There had also been events to celebrate diversity. A diversity day was held in October and there was an upcoming LGBT+ history day.

The trust had previously had a high number of whistle blowers contacting CQC. The number of these contacts had decreased in 2019 alongside a corresponding increase in the number of staff raising concerns within the organisation. This is indicative of an improving culture. Immediately prior to the inspection we received three whistle blower enquiries with two relating directly to the emergency department, patient care and culture. The third enquiry related to care on a surgical ward. During our inspection we found generally improved culture in the areas we inspected. However, there remained concerns about the culture and behaviours amongst medical staff within the emergency department (ED) which continued to impact on staff and the care within that area. At previous inspections we had found widespread cultural concerns within the ED, but a new, visible management team were making progress in staff feeling valued particularly with nursing staff. There was a greater acknowledgement that operational pressures that particularly impacted on the emergency department were an issue owned by the whole trust and not just the ED staff.

Since our last inspection the trust had employed a lead freedom to speak up guardian (FTSUG) who oversaw the other six guardians in the organisation. Since starting in post, they had taken a
mature approach to ensuring that FTSUG was visible and approachable in the organisation whilst ensuring a manageable workload. There were clear benefits already being shown by this appointment. In the preceding two years before their appointment there had been around 25 contacts to the FTSUG, in the nine months since the FTSUG lead had started there had been over 130 contacts. This increase in contacts correlates with the increase in staff raising concerns within the organisation to potentially demonstrate the improvement in culture and staff feeling able to speak up without being ostracised.

The lead FTSUG had excellent insight to the role and the potential conflict of interest if they were seen to be too close to the executives and were at pains to maintain their independence. They were also aware of ‘speak up fatigue’ that had occurred historically in other organisations. They had an excellent knowledge of the trust ‘hotspots’ as well as analysing the staff survey to identify areas of concern which were prioritised. A FTSUG was contactable every day and we saw posters and literature around the trust allowing staff to contact them should they need to. The FTSUG attended all trust inductions to explain their role. The FTSUG attended the hospital management board (HMB) bi monthly.

As we wrote in our last report, the Guardian of Safe Working Hours (GoSWH) is a senior appointment, that was introduced alongside the new junior doctor’s contract in 2016/2017. All organisations employing or hosting doctors in training are required to appoint a GoSWH. They are independent of trust management and champion adherence to safe working hours, oversee safety-related exception reports and monitor compliance with the system.

The GoSWH remained committed in engaging with medical staff in the organisation. The junior doctors forum was in place to enable junior medical staff to raise concerns in a supportive environment. The GoSWH had a good working relationship with the chief people officer and the medical director ensuring that any concerns raised were dealt with promptly. They reported an open culture in exception reporting. There had been a little over 1000 exception reports in the preceding three years with the GoSWH is notified of. They reported good engagement from the majority of specialities with only one fine levied.

The trusts People and Culture committee met monthly and reported to the HMB. The chair had taken an active role in engaging with staff and had increased the ‘walkabouts’ within the organisation. They were aware of the predominant issues in the Workforce Race Equality Standards (WRES) and could describe actions that were being taken to address these such as having BAME representatives on recruitment panels. The key focus of the committee was diversity and inclusion and engagement within the workforce particularly around pockets of bullying at the trust.

The trust’s culture was increasingly safety focused. The CEO was proud of the trusts HMSR, about underlying outcomes with culture of safety organisation wide. This was further supported (as mentioned previously) by an increase in the monthly speak up activity for FTSUG increased since April 2019 from 7 to 23 per month, the daily stand up SIG meeting in the operations centre which were open to all staff. for organisation wide learning (OWL). These were felt to be the fundamental building blocks to create sustained improvement in the culture of the trust.

Staff Diversity

The trust provided the following breakdowns of medical, nursing and allied health professional staff by ethnic group.
The trust had undertaken some significant work in addressing the equality and diversity in the workplace. We met with the equality and diversity leads at the trust who were able to describe the measures the trust had taken to improve the challenges identified. The trust had an action plan in place which demonstrated the compliance with their objectives. This included the interviewing of all BME staff who left the trust to ensure that the trust met their individual needs and identify areas for improvement. The executives had rolled out unconscious bias training throughout the trust and as of January 2020 managers were not able to recruit unless they had attended this training. The trust was also looking at other innovative ways of ensuring that staff recruiting did not display an unconscious bias.

Equality inclusion and diversity was more embedded at the time of this inspection. The trust had an equality, diversity and inclusion (EDI) overview document that set out overarching EDI objectives and goals in line with legislative requirements. This document was reviewed in August 2019 and linked to the overarching action plan as described above.

The trust had a Local Equality and Diversity Groups (LEDGegs) which fed into the Human Resources Equality and Diversity Group (HEDGe). This ensured that issues of equality and diversity were fed up and down the organisation. The HEDGe had recently been expanded to cover issues relating to equality and diversity in patients as well as staff. The group also monitored the impact of improvement through information like the number of BME staff going through disciplinary hearings. They found that this number was reducing and instead of being twice as likely to be involved in a disciplinary BME staff were now 1.5 times as likely. Whilst the trust recognised that this still required further work it does demonstrate some improvement. The trust was also about to start reverse mentoring to enable staff to appreciate differences.

Information provided by the trust identified that there was a dedicated email address in relation to equality and diversity that staff could use to contact and raise issues. Two staff networks had been established. These were the Black, Asian and Minority Ethnic (BAME) network and the Lesbian, Gay, Bisexual, Transgender, Queer or Questioning (LGBTQ) network. The trust had implemented the rainbow badge initiative which was awarded following completion of the training.

NHS Staff Survey 2018 results – Summary scores

The staff survey results have not changed since our previous inspection reported in May 2019. However, the trust had received confidential high-level results at the time of our inspection which demonstrated some improvement in a number of areas. However, this information is embargoed until mid-February, so we are unable to report on this in this report. The following illustration shows how this provider compares with other similar providers on ten key themes from the survey. Possible scores range from one to ten – a higher score indicates a better result.
The trust’s 2018 scores for the following themes were significantly lower (worse) when compared to the 2017 survey:

- Health and wellbeing
- Quality of care

There were no themes where the trust’s scores were significantly higher (better) when compared to the 2017 staff survey.

(Source: NHS Staff Survey 2018)

The 2018 staff survey identified areas for improvement in direct relation to morale and the impact this had on retention of staff. All executives were aware of the staff survey results and could describe the steps they had taken to improve things. The trust’s 2018 scores for Health and wellbeing and quality of care were significantly worse when compared to the 2017 survey. There were no significantly better scores as compared to the 2017 survey. For more detail on individual staff survey results from 2018 please see our last report.

**Workforce race equality standard**

Please note that the data is as reported in our inspection report published in May 2019. However, during this inspection, it is noted that the trust has developed and updated an action plan in response to the WRES standard. Please see section of staff diversity for further information.
The trust were aware of the work required to improve scores and outcomes under the WRES. There was a strategy in place to improve the experience of BME staff at the trust. The equality and diversity leads had an excellent undertaking of this issue nationally as well as at the trust. They were clearly focussed on putting patient experience at the centre of the strategy and the staff experience working at the trust. Equality and diversity networks were in place and these were beginning to raise issues through the local and hospital groups.

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts have to show progress against nine measures of equality in the workforce.

The scores presented below are indicators relating to the comparative experiences of white and black and minority ethnic (BME) staff, as required for the Workforce Race Equality Standard.

The data for indicators 1 to 4 and indicator 9 is supplied to CQC by NHS England, based on data from the Electronic Staff Record (ESR) or supplied by trusts to the NHS England WRES team, while indicators 5 to 8 are included in the NHS Staff Survey.

Notes relating to the scores:
- These scores are un-weighted, or not adjusted.
- There are nine WRES metrics which we display as 10 indicators. However, not all indicators are available for all trusts; for example, if the trust has less than 11 responses for a staff survey question, then the score would not be published.
- Note that the questions are not all oriented the same way: for 1a, 1b, 2, 4 and 7, a higher percentage is better while for indicators 3, 5, 6 and 8 a higher percentage is worse.
- The presence of a statistically significant difference between the experiences of BME and White staff may be caused by a variety of factors. Whether such differences are of regulatory significance will depend on individual trusts' circumstances.
As of 31 March 2018, two of the ESR staffing indicators shown above (indicators 1a to 3) showed a statistically significant difference in score between White and BME staff:

1a. In 2018, BME candidates were significantly less likely than White candidates to hold senior (band 8+) clinical roles (1.1% of BME staff compared to 4.4% of White staff). This remained similar to the previous year, 2017.

2. In 2018, BME candidates were significantly less likely than White candidates to get jobs for which they had been shortlisted (9.2% of BME staff compared to 19.1% of White staff). This remained similar to the previous year, 2017.

Of the four indicators from the NHS staff survey 2018 shown above (indicator 5 to 8), the following indicators showed a statistically significant difference in score between White and BME staff:

6. 39.0% of BME staff experienced harassment, bullying or abuse from staff in the past year (2018 NHS staff survey) which was significantly higher when compared to 29.5% of White staff. The score had remained similar to the previous year, 2017.

7. 74.3% of BME staff believed that the trust provided equal opportunities for career progression and promotion (2018 NHS staff survey) which was significantly lower when compared to 88.8% of White staff. The score had remained similar to the previous year, 2017.

8. 17.7% of BME staff experienced discrimination from a colleague or manager in the past year (2018 NHS staff survey which was significantly higher when compared to 7.0% of White staff. The score had remained similar to the previous year, 2017.

There were no BME Voting Board Members at the trust, which was not significantly different to the number expected, based on the overall percentage of BME staff.

(Source: NHS Staff Survey 2018; NHS England)

Results from the 2018 staff survey in relation to the equality, diversity and inclusion theme detailed an improvement in two of the four questions and a decline in two as follows:

• Q15a "In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?" This score had been slowly decreasing, therefore showing improvement, over the last three years with scores of 5.5% in 2016, 5.3% in 2017 and 5.2% in 2018. This was better than the average for similar acute trusts (6.1%).

• Q15b "In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?" Again, this score had seen an improvement, in the last 12 months with a score of 8.5% in 2017 reducing to 8.2% in 2018.

• Q14 "Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?" This score had declined from 87.2% in 2017 to 86.9% in 2018, however this remained above the average, better than, similar acute trusts (83.9%).

• Q28b "Has your employer made adequate adjustment(s) to enable you to carry out your work?"
This score had declined from 80.2% in 2017 to 76.5% in 2018, however this remained above the average, better than, similar acute trusts (72%).

**Friends and Family Test**

The patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment. The trust scored between 77.6% and 98.2% from October 2017 to September 2019.

The performance of this metric is not stable and may be subject to ongoing change. This would be worth investigating the cause on site.

**Friends and family test performance – Norfolk and Norwich University Hospitals NHS Foundation Trust – October 2017 to September 2019**

Norfolk and Norwich University Hospitals NHS Foundation Trust – response rate October 2017 to September 2019
Sickness absence rates

The trust’s sickness absence levels from August 2018 to July 2019 were similar to the England average.

(Source: NHS Digital)

General Medical Council – National Training Scheme Survey

In the 2018 General Medical Council Survey the trust performed the same as expected for all 18 indicators.

(Source: General Medical Council National Training Scheme Survey)

Governance
The trust had effective governance structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees and team meetings. There had been improvements in divisional governance that needed further embedding.

Since our last inspection, the board was complete with clear accountabilities.

There had been a governance review that was approved at trust board in November 2019. This was a periodic review of the governance structure and accountabilities. The outputs of the review included revised terms of reference for board sub committees and actions to enhance the governance of the trust.

The framework outlined clear responsibilities and accountabilities for the board, sub boards, sub committees and working groups. There was a well-defined structure of corporate governance, management committees and integrated governance. Patients and staff were identified as the key people throughout the governance review. The function of each committee was defined as was membership and quoracy. Link governors were aligned to specific sub committees. We were told at the inspection that the trust expected members of the patient panel to also attend committee.

Risk appetite had been reviewed and a level set for finance, regulatory and safety amongst others with a rationale for each. For example, safety had a low risk appetite as the trust expected services to be delivered safely with no harm to patients or staff. How the risk appetite was managed was demonstrated as was routes of escalation in the event the risk tolerance was exceeded.

Trust sub boards and committees were broadly divided into three functions; quality and safety, performance, and operational performance and transformation with some overlap between them.

The majority of these including the Mental Health Board, Risk Oversight Committee, Divisional Boards and Business Case Review Panel fed into the Hospital Management Board (HMB). The HMB as well as the Quality and Safety Committee, People and Culture Committee and Audit Committee amongst others fed directly into the Trust Board. Different aspects of governance such as clinical governance and finance governance had named executive leads, for example the chief nurse and medical director were the executive leads for clinical governance.

Assurance committee's such as the Quality and Safety Committee and the audit committee were chaired by NEDs. The Quality and Safety Committee received regular reports relating to serious incidents, safety, effectiveness and patient experience. The chair planned to support governors to participate in the sub board committees to broaden the challenge within the committees. The governors were aware that they would not be able to participate in decision making within the committees.

The Quality Programme Board (QPB) reported directly into the trust board and was where all quality improvements and transformation of services was examined and scrutinised. QPB was chaired by the chief executive with representation from the chair of the patient panel, executive directors and divisional leaders.

There had been increased devolvement of decision making to divisions and directorates within the divisions. This had increased independence and clinical, financial and operational decision making to the divisions. Information, risk and governance fed through the divisions to ensure a direct line of ward to board.

The divisions had been first introduced four years ago. There had been significant development of the divisions since our last inspection including greater autonomy. Divisional leaders and
managers reported an increasingly positive experience of the divisional structure. Investment in governance staff within the divisions had been positive with senior managers telling us that it not only reduced workload for them but made it easier to focus on their priorities. It was clear that these appointments were showing benefits with a need for further embedding of the role within the divisions. The divisions had a better understanding and clearer response to the concerns raised by staff we spoke with during our core service inspection.

The Integrated Performance Report (IPR) was an important way for the board to understand the quality of service and key to the ward board line of sight. We saw that the IPR was used effectively by the divisions to understand their current status as well as risk and priorities. This included clinical, operational and financial information. This information was reviewed at the divisional performance boards and from there on to the board. The IPR is produced for each division with an overarching summary produced for the Trust Board.

There had been a focus on quality and safety within the organisation. All executives we spoke with told us that cost improvement plans (CIPS) were not approved if they were quality damaging or if they were not a sustainable approach to managing either quality or finance. This had been enabled by the strong clinical leadership from the chief nurse and medical director. This was also supported by a renewed focus on these priorities from the divisions. The quality programme was owned by all staff not just executives. Review of minutes demonstrated an increasingly embedded approach to quality and safety with appropriate challenge.

Daily serious incident group (SIG) meetings had been introduced (Monday to Friday) prior to our last inspection and were now more embedded. They were open to all levels of staff to promote shared learning through open discussion. The SIG was chaired by either the chief nurse, medical director to review all incidents that had occurred in the previous 24 hours. This enabled identification of any immediate safety actions, shared learning and prompt oversight of any emerging themes or issues. In addition, a CEO assurance panel had been set up to review never events and the most complex serious incidents.

We directly observed a SIG meeting during our well led inspection. They remained constructive and were not seeking to apportion blame but identify immediate learning and actions to promote safe care. Those involved with the incident were asked to present where possible. There was excellent attendance from medical, nursing and other staff.

The medicines incident group also continued to operate in addition to the daily SIG group where all medicines incidents were reviewed. Pharmacy staff told us on the core services inspection that prompt review of medicines incidents was important as many incidents had implications for more than one clinical area. Serious incident reporting and learning was also disseminated through the IPR, governance leads and operational wide learning newsletters (OWLs).

Actions had started to raise the profile of both the staff and the patient voice at board however, not all plans were at the point of fruition and opportunities remained for this to be improved. The people and culture committee had recently been introduced and there were further plans in place for the establishment of a patient experience team. The chief nurse informed us that they had taken over the role of executive lead for complaints at the beginning of February 2019 and as such the patient advice and liaison services (PALS) would report into them. They were aware that the policy needed to be updated and a patient experience strategy put in place. A new lead for patient experience and engagement started at the trust on 1 March 2019.

The mental health board (MHB) continued to meet, chaired by the medical director which fed into the hospital management board. We reviewed the minutes of the MHB meeting from May 2019.
Minutes showed clear oversight of risk, incidents and additional items for discussion. There was also clear oversight of the CQC requirements made following previous inspections, particularly in the emergency department.

There was a full escalation policy and full capacity protocol in place. These were subject to ongoing review throughout the winter as we saw on the core services and well led inspections and the impending reconfiguration of the clinical decision’s unit. There were clear actions to follow for staff, managers and executives to follow. Whilst staff were clear about escalation policies there remained frustration in some clinical areas of the impact that escalation had, for example in the day procedure unit.

**Board Assurance Framework**

The board assurance framework (BAF) is a method of setting out the most important risks facing the organisation, the control framework to manage them, any gaps in the control and how the organisation satisfies itself that the controls are working as intended.

The trust provided their Board Assurance Framework, which details four strategic objectives within each and accompanying risks. A summary of the strategic objectives is below.

1. The trust will be a provider of high quality health and care services to the local population
2. The trust will be the centre for complex and specialist medicine for Norfolk and the Anglia Region
3. The trust will be a centre of excellence for research, education and innovation
4. The trust will be a leader in the design and delivery of health and social care services in Norfolk

We reviewed the BAF of September 2019 found that all the threats to strategic objectives RAG rated with mitigating actions. There were clear review processes and dates documented for each at relevant review committees and management board.

The BAF was discussed at trust board. Minutes showed appropriate assurance was received regarding control and mitigations.

*(Source: Trust Board Assurance Framework – September 2019)*

**Management of risk, issues and performance**

The arrangements for risk, issues and performance management had improved. There was better oversight of risk though some areas of concern remained, which needed to become fully embedded across the organisation. Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The trust had reviewed the arrangements risk identification and management, following previous inspections and an external review. There was a clear process of how risks were identified and escalated for inclusion on the risk register.

The trust continued to develop and implement its was a quality improvement plan (QIP). Senior managers told us that it was an evolving programme and process and would go beyond the concerns raised at previous inspections. This had initially been designed with input from staff and
we found staff were still central in managing quality improvement. This approach had improved staff ownership of quality and safety in the divisions and wider trust. The QIP was monitored internally and was also monitored bi-monthly at the multiagency oversight assurance group attended by NHSE/I, CQC, the local CCG and Healthwatch amongst others. The trust utilised a red, amber, green and blue rating system to indicate progress against actions.

At our last inspection we were concerned that the trust QIP did not fully reflect our inspection findings of 2018. At this inspection we saw that risk oversight overseen by the risk oversight committee chaired by the chief nurse, (including but not limited to our previous inspection findings) was more comprehensive and discussed regularly. A formal meeting considered risks and actions to mitigate them. Actions form previous inspections were only closed off when there was consistent robust assurance that they had been met.

At this inspection we saw there had been improvement in a number of areas. However, it was evident at an early stage of our core services inspection that the emergency department was not following the standard operating procedures (SOPs) that has been instigated following our serving of a Warning Notice in 2019 regarding the management of patients in the emergency department. Whilst this was rectified promptly when we raised the concern with executives, we were concerned that there was not robust oversight of the implementation of the SOP in the emergency department or monitoring of their effectiveness.

We were also concerned that issues with medicines management found in the emergency department, on wards and in outpatients were not all identified in the risk management process. Trust executives told us that risk management was continuing to embed throughout the organisation and was partly aligned to the cultural work being carried out across the trust.

Senior management committees and the board reviewed performance reports. Each board meeting reviewed the redesigned IPR. This covered quality, safety and effectiveness, caring and patient experience and performance amongst others. It was a key way of considering the risks and performance of the divisions as well as the trust as a whole. The divisional triumvirates were responsible for the management of risk within their division which they considered at monthly meetings. They were able to escalate risk at the monthly divisional performance meetings.

There were continued pressures on the organisation regarding performance. The executives all were well sighted on the challenge of performance. The RTT recovery plan was discussed monthly and agreed with commissioners. The increase in capacity aimed to improve flow and reduce the use of escalation wards in the trust allowing those clinical areas to operate more effectively and for their intended purpose.

The executive directors, chair and non-executive directors we spoke with all agreed on the most significant risks for the organisation. These included finance, staffing, and capacity. This was completely aligned to the trust risk register as well as the BAF. All could describe the controls in place and their individual responsibilities in addressing these concerns. The board felt that the risks were accurately representative and that there was good oversight from divisions, board subcommittees and the trust board.

There was recognition from the executives that they needed to rebalance capacity across the trust as this was impacting on risk and safety. There were additional beds due to open in February 2020, but the trust was also continuing to work on the flow of patients within the organisation, this included ring fencing beds on a ward until later in the day so that there were beds for use to admit patients form the emergency department. Early indications were this was making a positive improvement. There was ongoing work with the STP, there was continued work on patient clinical
pathways to ensure patients received the best treatment and the most appropriate place whilst ensuring sustainability.

The trust was undertaking lead provider work across the STP for certain clinical and non-clinical work. There was increased working between organisations that was producing positive benefits. It was clear that executives were not thinking only of The Norfolk and Norwich in developing plans for the future but recognised that joint working was required to ensure safe, sustainable services.

The medical director had identified rota’s in a number of areas that were not functioning. The outcome was unhappy staff in some areas and a failure to adequately cover clinical areas with the correct specialties. Job planning had not been carried out previously at the trust but was now being undertaken with around 85% completed.

Mortality and morbidity meetings were now held regularly across the divisions and the format standardised. Outcomes from the M and M meetings went through the clinical effectiveness committee. In response to a rising SHMI which was not in line with the HSMR, the trust was undertaking a proactive cohort review of deaths post 30 days discharge. The medical examiners were now embedded within the trust. Whilst the majority of deaths were reviewed, some were excluded including the very elderly expected deaths.

Emergency planning and business continuity processes were in place. Monitoring was undertaken through a resilience group and reported through to the trust board.

### Finances Overview

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Previous Financial Year (2017/18)</td>
<td>Last Financial Year (2018/19)</td>
</tr>
<tr>
<td>Income</td>
<td>£586.7m</td>
<td>£599.7m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£19.6m)</td>
<td>(£60.6m)</td>
</tr>
<tr>
<td>Full Costs</td>
<td>(£606.3m)</td>
<td>(£660.3m)</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>£4.6m</td>
<td>(£53.6m)</td>
</tr>
</tbody>
</table>

The deficit reported in 2018/19 was larger than the previous year, when a surplus was reported. Figures for April to August 2019 indicated that the deficit will decrease, similarly the projections for 2020/21 predict that this will continue to fall.

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

During the inspection we found that not all of the trust executives understood the financial issues facing the trust as a collective board. Given the financial status of the trust we found that financial sustainability was not given sufficient comment in many conversations. The trust had had no capital equipment replacement plan until this year, and we were aware that the business case process was newly in place. The chief executive understood that there was significant work to do on financial stewardship but that there was a good sense of what was required to meet the challenge of improving services.

While there was an improving culture of high quality care, there was less evidence of a culture of sustainable care. Sustainability, financial improvement and/or productivity were not prominent
features described when Board members described the Trust strategy, plans, vision or values. The Trust has recently implemented an accountability framework which is yet to be embedded, and there is a lack of evidence that processes are effective at mitigating identified financial risks, issues and improving performance.

There were concerns around how much importance board as a whole dedicated to financial delivery as very much weighted towards quality so need to ensure both are well balanced & considered.

**Trust corporate risk register**

We found that the trust risk register was held electronically which meant it could be accessed, reviewed and updated by governance teams at any point. We found this to be detailed with clear mitigations, ownership of risk and meeting minutes showed that they were regularly reviewed, and progress monitored. The risk register and its format had changed over time.

However, the paper copy of the document that was given to NED’s was a reduced version that was missing a number of columns which would have been on the electronic spreadsheet. This meant that NED’s would find it impossible to fully understand the risks, response to the risks and any review that had been carried out. This was of particular concern given the number of the NED’s were new in post.

The trust provided a document detailing their 35 highest profile corporate risks. Each of these have a current risk score of 15 or higher (out of 20). The 17 risks with the highest score of 20 are detailed below:

<table>
<thead>
<tr>
<th>Date risk opened</th>
<th>ID</th>
<th>Description summary</th>
<th>Risk score (current)</th>
<th>Risk level (target)</th>
<th>Last review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/09/2015</td>
<td>571</td>
<td>Not meeting key local and national performance targets for the emergency department, referral to treatment times and cancer waits</td>
<td>20</td>
<td>9</td>
<td>03/04/2019</td>
</tr>
<tr>
<td>02/09/2015</td>
<td>572</td>
<td>Not being financial sustainable due to the size and complexity of the Cost Improvement Programme and the potential failure of living within the challenging financial targets</td>
<td>20</td>
<td>8</td>
<td>01/04/2019</td>
</tr>
<tr>
<td>02/08/2018</td>
<td>610</td>
<td>Lack of investment and continued use of aged IT infrastructure leading to the IT infrastructure failing and critical services not functioning</td>
<td>20</td>
<td>10</td>
<td>01/04/2019</td>
</tr>
<tr>
<td>02/10/2018</td>
<td>619</td>
<td>Not making the improvements required to be removed from special measures</td>
<td>20</td>
<td>8</td>
<td>31/07/2019</td>
</tr>
<tr>
<td>31/10/2018</td>
<td>623</td>
<td>Not delivering the financial plan for 2018/19</td>
<td>20</td>
<td>16</td>
<td>01/04/2019</td>
</tr>
<tr>
<td>Date</td>
<td>ID</td>
<td>Issue Description</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>-----</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31/10/2018</td>
<td>624</td>
<td>Not agreeing a medium term financial strategy in breach of financial licence.</td>
<td>20 12 01/04/2019</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28/12/2018</td>
<td>651</td>
<td>Inability to comply with the UK’s Network and Information Systems Regulations 2018 as a defined operator of essential services, due to a lack of people, technology, training, appropriate processes and pockets of shadow IT.</td>
<td>20 8 01/04/2019</td>
<td></td>
<td></td>
</tr>
<tr>
<td>02/04/2019</td>
<td>731</td>
<td>Servers running Microsoft SQL Server 2000 and Windows 2003 Server Operating System which are out of date and no longer supported by Microsoft</td>
<td>20 10 02/04/2019</td>
<td></td>
<td></td>
</tr>
<tr>
<td>02/04/2019</td>
<td>732</td>
<td>Weak domain passwords used by around 10% of active user accounts</td>
<td>20 10 02/04/2019</td>
<td></td>
<td></td>
</tr>
<tr>
<td>02/04/2019</td>
<td>733</td>
<td>Hosts connected in the domain not being managed by the centralised update management system for Microsoft updates, no centralised system for managing third-party software updates in active use and no regular reviews in place for systems that were not successfully patched.</td>
<td>20 10 02/04/2019</td>
<td></td>
<td></td>
</tr>
<tr>
<td>02/04/2019</td>
<td>734</td>
<td>Files available in the domain containing credentials, and other potentially sensitive system information in clear text.</td>
<td>20 10 02/04/2019</td>
<td></td>
<td></td>
</tr>
<tr>
<td>02/04/2019</td>
<td>735</td>
<td>IT access controls not being applied consistently, leaving a vulnerability to malware spreading through the network.</td>
<td>20 10 02/04/2019</td>
<td></td>
<td></td>
</tr>
<tr>
<td>03/04/2019</td>
<td>738</td>
<td>Desktops and laptops missing a number of critical Windows updates, relating to vulnerabilities that could potentially allow remote code execution.</td>
<td>20 5 03/04/2019</td>
<td></td>
<td></td>
</tr>
<tr>
<td>03/04/2019</td>
<td>739</td>
<td>Desktops and laptops running old versions of client software.</td>
<td>20 5 03/04/2019</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Information management
The trust collected, managed and used information well to support all its activities. Digital immaturity remained a risk to the organisation and its data security.

There had been a focus on improving data quality to further improve the performance, safety and quality of services at the trust. The new Integrated Performance Report (IPR) made use of a range of information to enable managers at all levels to monitor their clinical and non-clinical areas. We were told there was an audit programme of the data points within the IPR to ensure robust data was used when bringing the IPR together. Whilst the IT systems needed investment and integration, the information systems introduced for data analysis were performing well and had improved the quality of analysis within the trust.

There had been ad hoc purchasing and commissioning of IT systems at the trust. This meant that the digital infrastructure was of different ages, capabilities and compatibilities and as such not all systems were integrated. The trust had been rated amongst the lowest for digital maturity.

The trust had a chief information officer (CIO) as part of the executive team. There was a digital strategy in place which outlined an ambitious investment programme at the trust but more widely across Norfolk. There was recognition that Norfolk as a system was digitally immature and the most effective investment for transformation would be across the STP.

The IT strategy highlighted the key priorities areas for developing digital maturity. This included electronic document management and electronic observations amongst others. The CIO was well sighted on the particular challenges for the trust in relation to digital maturity such as the PFI status of the trust. The executives recognised that the implementation of an electronic patient record, particularly across organisations was a project that would take some time but were committed to moving it on.
There had been some success in developing systems across the STP. At the time of our inspection the 'My care record' was about to go live. This would allow GP’s and others such as the ambulance service to access care details including diagnostic tests carried out at the trust. This should significantly improve communication between professionals whilst ensuring they have information to make appropriate, safe clinical decisions.

The CIO was clear about the risks of cyber-attacks for the organisation. Action plans were in place to address the riskiest areas which included the need to upgrade from Windows 7 to a more up to date operating system. The financial challenge made this difficult and there had been a delay in implementation. The progress of these action plans was overseen by the Digital transformation Committee.

A number of staff told us that management at all levels of the organisation were too busy with day to day operational matters to use information in a more detailed way. The triumvirates told us that the additional governance role in the division had improved this though there was a recognition that staff needed time to fully understand the volume of data and information in their areas.

The governance review of November 2019 demonstrated the flow and reporting of information effectively ward to board. This included management information as well as divisional reports amongst much else. The structure showed which committees’ information should go to as well as the route of information to the trust board.

The corporate risk register included a number of IT risks including security risks, obsolete software and hardware and IT access. There were mitigations in place to manage the risks, but senior managers were aware that the resolution of the risks required significant investment. Managers were also aware at how frustrated some staff were in using dated technology.

The chief information officer was the senior information risk owner (SIRO) for the trust and the Medical Director was the Caldicott guardian for the trust.

**Engagement**

*Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. However, whilst patient engagement was improving it required further work.*

At the previous inspection in January 2019 we found that there had been some initiatives to improve engagement with staff through a number of semi informal meetings. However, at this inspection there were a number of avenues that staff could engage with the senior team through including: team brief which was cascaded throughout the organisation, divisional newsletters and clinical newsletter to staffing groups. The senior leadership team engaged with staff on a face to face basis and advertised these events so that staff could attend. Staff reported that the senior leadership team was increasingly visible and that they could access them following a number of meetings or in an ad-hoc way.

Following our last report, the senior team had embraced the changes that were needed in the emergency department. The trust had supported the development of clinical leadership in certain areas such as the emergency department that had had a positive impact on staff engagement and increased visibility of leaders in those areas.
The trust continued to run development programmes for staff in different roles as well as for teams including divisional managers and others. The trust recognised that they continued to score poorly on the 2018 NHS Staff Survey for the proportion of staff who report bullying or poor behaviours. Initiatives in place continued to address these concerns including the dignity at work framework and ‘Rudeness costs lives’.

The FTSUG had made positive moves in engaging staff across the trust. Whilst they had focussed initially on ‘hotspots’ and nursing staff, they were beginning to engage with other staff across the trust. Staff we spoke with were aware of the FTSUG and were confident in how to approach them.

There was external engagement with partners and stakeholders. For example, the medical director met regularly with the local medical committee (LMC) both formally and informally and recognised this as an important relationship with GP colleagues in the community. There had been increased participation in the sustainability transformation plan and the senior leadership team met regularly and engaged with their counterparts across the county. The trust senior leadership team also offered support and joint working opportunities to other organisations across the county. Relationships in the past had been challenging but were now more open and responsive to the needs of people using services. The appointment of a number of local authority senior staff as non-executive directors also assisted with the strengthening of relationships with the local authority.

At our previous inspections we found that the trust had a poor level of engagement with patients and the wider public. At this inspection it was clear that work was underway to improve this. There was now a patient engagement and experience strategy that was in place. The trust previously did not have a strategy for this engagement. The strategy had four priorities for engagement including strengthening partnership working with patients and creating a culture where staff really listen to patients and take action in response. There had been significant investment into engagement roles with senior staff in post to drive change.

A patient panel had been formed and was chaired by a person with extensive experience in patient voice roles. There were currently 8 people on the panel with a plan to increase this to 20 in the coming months. The panel chair was clear that they were looking for active members with complementary experience to sit on the panel and were recruiting in that way. The dynamic leaders were passionate about raising the profile of the panel and patient engagement in the organisation.

The trust had a strong and supportive volunteer service with over 700 volunteers. Volunteers were visible around the trust supporting patients and visitors. Volunteers were also a source of information from patients and this was used to improve services for patients. One of the volunteers had been awarded a staff award at the recent presentation ceremony.

The trust had promoted the benefits to patients of staff receiving the flu vaccination. This had resulted in the trust being named as the best in the East of England region in the uptake of the vaccination for staff.

**Learning, continuous improvement and innovation**

The trust had significantly increased its capacity for quality improvement, science, sharing and learning from events and innovation.

Staff had been supported to attend quality improvement training, including ‘train the trainer’ training so that more staff could access QI methodology. There had been significant investment in the divisions for leadership and organisational development which managers told us had been positive.
Complaints process overview

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3</td>
<td>98%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>As agreed with complainant</td>
<td>84%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months?</td>
<td>2,701</td>
<td>(August 2018 – July 2019)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)

Number of complaints made to the trust

The trust had a formal policy and process in place for complaints. This was initially managed through the patient advice and liaison service (PALS). The chief nurse was the named executive responsible for complaints and saw each complaint and trust response before it was sent to the complainant.

Complaints were shared with the divisions and were discussed at monthly divisional meetings. The divisions were responsible for following up and monitoring progress on actions to ensure the complaint was properly managed and any learning identified. Complaints, themes and actions were heard at a board subcommittee.

We reviewed a number of complaints during the core services inspection and found that they were investigated properly. Staff in most areas could tell us about complaints in their area and what lessons had been learnt. We found during the core service inspection in January 2019 that complaints were investigated appropriately, handled and responded to effectively and that lessons were shared in the majority of services.

From August 2018 to July 2019, the trust received a total of 1,077 complaints. The highest number of complaints were for medical care, with 24.8% of total complaints, followed by surgery (21.5% of complaints) and outpatients (18.1%).

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care</td>
<td>267</td>
<td>24.8%</td>
</tr>
<tr>
<td>Surgery</td>
<td>232</td>
<td>21.5%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>195</td>
<td>18.1%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>133</td>
<td>12.3%</td>
</tr>
<tr>
<td>Provider wide</td>
<td>65</td>
<td>6.0%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>41</td>
<td>3.8%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>41</td>
<td>3.8%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>41</td>
<td>3.8%</td>
</tr>
<tr>
<td>Maternity</td>
<td>36</td>
<td>3.3%</td>
</tr>
<tr>
<td>End of life care</td>
<td>14</td>
<td>1.3%</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>0.8%</td>
</tr>
</tbody>
</table>
Compliments

From August 2018 to July 2019, the trust received a total of 1,866 compliments. The highest number of compliments were for medical care, with 38.7% of total compliments, followed by surgery (25.8% of compliments) followed by urgent and emergency services (6.2%).

A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care</td>
<td>723</td>
<td>38.7%</td>
</tr>
<tr>
<td>Surgery</td>
<td>481</td>
<td>25.8%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>116</td>
<td>6.2%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>97</td>
<td>5.2%</td>
</tr>
<tr>
<td>Maternity</td>
<td>97</td>
<td>5.2%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>88</td>
<td>4.7%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>68</td>
<td>3.6%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>64</td>
<td>3.4%</td>
</tr>
<tr>
<td>End of life care</td>
<td>54</td>
<td>2.9%</td>
</tr>
<tr>
<td>Critical care</td>
<td>31</td>
<td>1.7%</td>
</tr>
<tr>
<td>Provider wide</td>
<td>26</td>
<td>1.4%</td>
</tr>
<tr>
<td>Other</td>
<td>21</td>
<td>1.1%</td>
</tr>
</tbody>
</table>

The trust has had a drive to improve collection and recording of compliments since January 2019. Compliments are reported monthly to the Patient Engagement and Experience Group and there is a monthly analysis of themes. Divisions can access their data themselves for use at local level for sharing and learning from. Trust wide themes are being identified and show how important care, kindness and staff attitude are to the positive experience of patients. Dignity is also a key positive theme.

A selection of compliments are shared via Comms briefings and individual wards and areas display and share their compliments amongst teams.

Accreditations

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which of the trust’s services have been awarded an accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
<th>Services engaged but not yet accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>Endoscopy Suite - achieved 23 June 2016. Global rating scale</td>
<td>Paediatric endoscopy are engaged in setting up the</td>
</tr>
</tbody>
</table>
(GRS) certificate achieved 14 August 2017.
Quadram and Endoscopy Suite - Achieved May 2019

<table>
<thead>
<tr>
<th>Service/Standard</th>
<th>Date/Accreditation Details</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthesia Clinical Services Accreditation (ACSA)</td>
<td>Accredited 1 July 2019</td>
<td>-</td>
</tr>
<tr>
<td>Imaging Services Accreditation Scheme (ISAS)</td>
<td>Radiology has been accredited for 6 years</td>
<td>-</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation and it's successor Medical Laboratories ISO 15189</td>
<td>Biochemistry, Haematology, and Microbiology accredited 30 September 2018; Cellular Pathology, consisting of histopathology and cytopathology, gained accreditation in January 2017, after inspection in March 2016. This has been maintained in two subsequent surveillance visits in August 2017 and 2018; the next surveillance visit is scheduled for 18 September 2019. The mortuary was inspected by the Human Tissue Authority in December 2016 and has licence number 11208</td>
<td>-</td>
</tr>
<tr>
<td>CHKS Accreditation for radiotherapy and oncology services</td>
<td>CHKS provides accreditation service for ISO 9001; the trust uses BSI. The current ISO 9001: 2015 certificate runs until 26 April 2019.</td>
<td>-</td>
</tr>
<tr>
<td>MacMillan Quality Environment Award (MQEM)</td>
<td>Accredited 10 December 2014</td>
<td>-</td>
</tr>
<tr>
<td>IQIPS via UKAS for adult rehabilitation and paediatric audiology</td>
<td>Audiology out-patient department accredited 2016</td>
<td>-</td>
</tr>
<tr>
<td>ISO 13485:2016</td>
<td>Central Sterilisation Services Department</td>
<td>-</td>
</tr>
<tr>
<td>Baby Friendly Service</td>
<td>November 2018</td>
<td>-</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Accreditations tab)

The trust had excellent links with local academia and wider industry. The Vice Chancellor of the neighbouring university sat on the board as a non-executive director. They also chaired the people and culture committee. A number of people we spoke with including those involved in research told us about the importance and benefits of close links with universities.

A five year research strategy had recently been adopted alongside the creation of two new senior research posts, a director of research operations and an associate medical director for research. The strategy was comprehensive and looked to build on previous research at the Norfolk and
Norwich. It clearly identified that research was important as trusts with more research activity have better patient outcomes. Four achievable goals had been identified for the strategy and it was clear there was broad executive support for research within the organisation. Research sub committees fed into the Research Oversight Board which in turn fed into the HMB. Leaders in research were committed and passionate about the development of research at the trust.

There was an increased focus on quality improvement (QI) within the organisation and development of a QI faculty which will integrate system wide. There was recognition that this change of a top down culture may take some time, but clinical staff were being supported to attend QI training. There was a shared approach to QI. Seven QI trainers were in post and were taking a single consistent approach to a QI strategy & cascading this across the trust.

Areas of innovation, which had received national recognition for, was the Older People Emergency Department (OPED), which focuses on resilience and frailty. The was also a focus on Urology robotics which had been deployed.

The trust was actively involved with the Getting it Right First Time (GiRFT) reviews. All of the outcomes of GiRFT reviews were considered by the medical director and action plans developed to embed best practice if this was required. The trust had recently recruited a radiology lead for GiRFT.

25% of income for the trust is from specialist service. Examples of this included a rheumatology centre of excellence, specialist centre for cancer as well as a regional vascular team.
**Acute services**

**Norfolk and Norwich Hospital**  
Colney Lane  
Norwich  
Tel: 01603 286286  
www.nnuh.nhs.uk

**Urgent and emergency care**

**Facts and data about this service**

The trust has a type 1, major injuries unit at Norfolk and Norwich University Hospital and a minor injuries unit at Cromer Hospital.

The major injuries unit is equipped with:
- Six resuscitation spaces including a paediatric assessment space and cardiac bay.
- Sixteen majors cubicles and space for three trolleys for patients awaiting ward transfer.
- Six minors cubicles and a plaster room.
- Five ambulatory rooms for GPs co-located with minors.
- Eight rapid access trauma service (RATS) cubicles.
- Three dedicated quiet rooms.
- 12 clinical decisions unit (CDU) spaces.
- Nine children’s emergency department (ChED) cubicles and a dedicated waiting area.
- Four older people’s emergency department (OPED) cubicles.
- Two OPED side rooms and a dedicated waiting area.

The minor injuries unit has four treatment spaces operating from 8am to 8pm seven days per week.

General practitioner (GP) cover is from 8am to 11pm seven days a week and is mainly for ambulatory illness. Appropriate patients requiring GP intervention are streamed on arrival at the emergency department to the urgent care centre. Ambulance arrivals can be referred to the urgent care centre once the patient has been assessed in the emergency department.

The emergency department also hosts an early intervention therapies team (EIT) seven days a week, with a physiotherapist, occupational therapist, rapid discharge planning and admission avoidance service.

(Source: Routine Provider Information Request (RPIR) – Acute context tab)

**Activity and patient throughput**

Total number of urgent and emergency care attendances at Norfolk and Norwich University Hospitals NHS Foundation Trust compared to all acute trusts in England, July 2018 to June 2019
From July 2018 to June 2019 there were 144,238 attendances at the trust’s urgent and emergency care services as indicated in the chart above.

(Source: Hospital Episode Statistics)

**Urgent and emergency care attendances resulting in an admission**

The percentage of A&E attendances at this trust that resulted in an admission increased in 2018/19 compared to 2017/18. In both years, the proportions were higher than the England averages.

(Source: NHS England)

**Urgent and emergency care attendances by disposal method, from July 2018 to June 2019**
During our inspection we spoke with 63 members of staff including matrons, nurses, health care assistants, doctors, junior doctors, consultants, paediatric doctors, and nurses. We also spoke with housekeeping staff, reception staff, deputy safeguarding adults lead, advanced care practitioners, psychiatric liaison staff, emergency department flow coordinators, the clinical director, and operations manager.

We inspected the ambulatory minors, resuscitation area including a paediatric assessment space and cardiac bay, majors and minors, rapid assessment and treatment (RAT), the clinical decisions unit (CDU), paediatric ED, the older people’s ED (OPED) and reception areas.

Following our previous inspection in January 2019, we issued an S29A Warning Notice having found some significant ongoing concerns in the urgent and emergency service. We followed up these concerns during our inspection on the 10/11/ and 12 December 2019 and found that the trust had made significant efforts to become compliant.

We spoke with 14 adult patients, six relatives and one child to ask about their experience of care.

We also spoke with senior staff who were part of the trust’s new management team within the emergency department that replaced the trust’s previous “Winter Pressures Team”. The winter pressures team had been formed in January 2019 to deal with access and flow through the department during the winter period. However, the new team were focused on managing flow throughout the whole year to deal with the increasing demands placed on the trust’s urgent and emergency services.

We reviewed 34 sets of patient records in relation to their care, treatment and medication. We also reviewed policies, procedures and guidelines within the emergency department and reviewed equipment to ensure it was clean and serviced in line with manufacturer guidance.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or...
discriminatory abuse.

**Mandatory training**

The service provided mandatory training in key skills including life support training. However, they did not make sure all staff completed it.

**Mandatory training completion rates**

Nursing and medical staff did not keep up-to-date with their mandatory training.

The trust set a target of 90% for completion of mandatory training.

**Trust level**

A breakdown of compliance for mandatory training courses from August 2018 to July 2019 at trust level for qualified nursing staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
<td></td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>143</td>
<td>162</td>
<td>88.3%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Clinical record keeping</td>
<td>127</td>
<td>145</td>
<td>87.6%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>140</td>
<td>162</td>
<td>86.4%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Information governance</td>
<td>136</td>
<td>162</td>
<td>84.0%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Medicine management training</td>
<td>120</td>
<td>146</td>
<td>82.2%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Fire safety</td>
<td>133</td>
<td>162</td>
<td>82.1%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Basic life support</td>
<td>116</td>
<td>147</td>
<td>78.9%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>105</td>
<td>134</td>
<td>78.4%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>98</td>
<td>140</td>
<td>70.0%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Infection prevention (level 2)</td>
<td>97</td>
<td>146</td>
<td>66.4%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Resuscitation</td>
<td>93</td>
<td>146</td>
<td>63.7%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Prevention and management of aggression</td>
<td>82</td>
<td>137</td>
<td>59.9%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>86</td>
<td>147</td>
<td>58.5%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

In urgent and emergency care the 90% target was not met for any of the mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from August 2018 to July 2019 at trust level for medical staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Clinical record keeping</td>
<td>40</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>44</td>
</tr>
<tr>
<td>Fire safety</td>
<td>42</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>37</td>
</tr>
<tr>
<td>Information governance</td>
<td>39</td>
</tr>
</tbody>
</table>
In urgent and emergency care the 90% target was met for one of the 13 mandatory training modules for which medical staff were eligible (clinical record keeping) with the health and safety (slips, trips and falls) module having a completion rate just below the target.

Norfolk and Norwich University Hospital urgent and emergency care department

A breakdown of compliance for mandatory training courses from August 2018 to July 2019 for qualified nursing staff in urgent and emergency care at Norfolk and Norwich University Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>135</td>
</tr>
<tr>
<td>Clinical record keeping</td>
<td>120</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>132</td>
</tr>
<tr>
<td>Information governance</td>
<td>128</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>114</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>105</td>
</tr>
<tr>
<td>Basic life support</td>
<td>109</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>98</td>
</tr>
<tr>
<td>Infection prevention (level 2)</td>
<td>90</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>86</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>79</td>
</tr>
</tbody>
</table>

In urgent and emergency care the 90% target was not met for any mandatory training modules for which qualified nursing staff at Norfolk and Norwich University Hospital were eligible.

A breakdown of compliance for mandatory training courses from August 2018 to July 2019 for medical staff in urgent and emergency care at Norfolk and Norwich University Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
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<tbody>
<tr>
<td></td>
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<td>44</td>
</tr>
<tr>
<td>Fire safety</td>
<td>42</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>37</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>39</td>
</tr>
</tbody>
</table>

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In urgent and emergency care the 90% target was met for one of the 13 mandatory training modules for which medical staff at Norfolk and Norwich University Hospital were eligible. The health and safety (slips, trips and falls) module had a completion rate just below the target.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The mandatory training was comprehensive, however not all staff completed this.

At our last inspection we found staff training rates were below trust compliance targets. During this inspection data provided by the trust showed compliance levels still fell below the required compliance levels. Following our inspection, the trust told us they had implemented additional team-based mandatory training days and increased the departments overall mandatory training compliance rate from 73.7% in February 2019 to 85.6% in February 2020, just below the 90% trust target.

Staff accessed training through online learning and face-to-face training sessions. Staff we spoke with said they no longer had mentor days. Mentor days used to be provided by more experienced staff. This was due to the recruitment of more junior nursing staff and a change in the staff skills mix within the ED. All staff we spoke with were positive about the trust’s training activities and were able to demonstrate how they could access a wide range of learning materials on the trust’s intranet system. However, managers recognised staff did find it difficult to access training at times due to the increased patient demand within the department.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers we spoke with said they prioritised training. As the emergency department (ED) had increased its staff team, managers were focused on improving training rates. We spoke with the practice development nurse who showed us the ED training plan and the current training figures for the department. The training plan demonstrated that managers understood where there were gaps in mandatory training and showed how they prioritised additional dates in 2020 to give staff training updates.

Medical staff we spoke with told us that teaching and training for doctors was positive at the trust. Teaching sessions were delivered on a wide range of core skills and we observed that during medical staff handovers, managers used ‘lightening learning’ to share additional training. For example, we observed one learning session on the use of a tourniquet in major haemorrhage. A tourniquet is a device which applies pressure to a limb or extremity so as to limit, but not stop the flow of blood. It may be used in emergencies, in surgery, or in post-operative rehabilitation.

**Safeguarding**

Not all staff had training on how to recognise and report abuse.

Safeguarding training completion rates
The trust set a target of 90% for completion of safeguarding training.

The tables below include prevent training as a safeguarding course. Prevent works to stop individuals from getting involved in or supporting terrorism or extremist activity.

**Trust level**

A breakdown of compliance for safeguarding training courses from August 2018 to July 2019 at Trust level for qualified nursing staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Prevent - level 3</td>
<td>122</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>115</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>111</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>3</td>
</tr>
</tbody>
</table>

In urgent and emergency care the 90% target was not met for any of the safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from August 2018 to July 2019 at trust level for medical staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>36</td>
</tr>
<tr>
<td>Prevent - level 3</td>
<td>32</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>33</td>
</tr>
</tbody>
</table>

In urgent and emergency care the 90% target was not met for any of the safeguarding training modules for which medical staff were eligible.

**Norfolk and Norwich University Hospital urgent and emergency care department**

Not all nursing and medical staff received training specific for their role on how to recognise and report abuse.

A breakdown of compliance for safeguarding training courses from August 2018 to July 2019 for qualified nursing staff in urgent and emergency care at Norfolk and Norwich University Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Prevent - level 3</td>
<td>115</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>110</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>104</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>3</td>
</tr>
</tbody>
</table>
The 90% target was not met for any of the safeguarding training modules for which qualified nursing staff in urgent and emergency care at Norfolk and Norwich University Hospital were eligible.

A breakdown of compliance for safeguarding training courses from August 2018 to July 2019 for medical staff in urgent and emergency care at Norfolk and Norwich University Hospital is shown below:

<table>
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</tr>
<tr>
<td>Prevent - level 3</td>
<td>32</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>33</td>
</tr>
</tbody>
</table>

The 90% target was not met for any of the safeguarding training modules for which medical staff in urgent and emergency care at Norfolk and Norwich University Hospital were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Following our inspection, we asked the trust for additional data regarding safeguarding training compliance. Data showed that 89% of nursing staff achieved compliance with safeguarding adults’ level two and medical staff achieved 80% compliance. 71% of nursing staff achieved compliance with safeguarding children level three and medical staff achieved 57% compliance.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. The trust had designated leads for safeguarding adults and children. We spoke with the deputy safeguarding adult lead and reviewed the safeguarding children’s policy and safeguarding adult’s policy. Both policies were up to date and in line with current guidance. Staff spoke with knew the protected characteristics and gave examples of how to protect patients’ rights. For example, one staff member explained how they were supporting a patient with a learning disability. We noted they had ensured the patient care plan involved the trust’s learning disability nurse to provide additional guidance and least restrictive care.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff received training on how to recognise and report different forms of abuse, including domestic violence, female genital mutilation (FGM), modern slavery, child sexual abuse and fabricated illness amongst other key areas. The deputy safeguarding lead explained how the trust’s safeguarding training had been developed to meet the intercollegiate guidance Adult Safeguarding: Roles and Competencies for Health Care Staff. Staff completed a full day face-to-face training session to achieve level three safeguarding adults and level three children. This had affected staff training rates due to staff needing a full day away from their normal duties, which was not always possible. The trust had a clear plan to ensure all staff were qualified to the appropriate levels by 2021.

Staff could identify patients who attended the ED more frequently, as each ED attendance was flagged within the patient electronic record. Children who attended the ED more than three times in a three-month period were automatically highlighted for a safeguarding review by staff and the trust policies gave clear guidance to staff on how to follow up on any frequent attenders.

If staff were concerned about a possible non-accidental injury to a child, they immediately referred this to a senior consultant and completed a referral to the internal safeguarding team.
Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff knew and could explain to us their responsibilities in relation to FGM, how to contact the safeguarding teams and make a safeguarding referral. We noted key guidance on safeguarding displayed on walls around the ED, posters next to staff work stations and on the trust’s intranet site.

Staff followed safe procedures for children visiting the ward. The emergency department had a dedicated children’s emergency department separated from adult assessment and treatment areas. Staff within the children’s ED team completed appropriate training and additional competencies to meet the needs of children.

Cleanliness, infection control and hygiene

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

All ward areas were clean and had suitable furnishings which were clean and well-maintained. Housekeeping staff were visible in the department throughout our inspection, engaged in cleaning activities and emptying waste bins frequently during the day.

The service generally performed well for cleanliness. Hand hygiene audit data provided by the trust showed the hand hygiene compliance rate on 16 September 2019 was 100%, 97% on 24 October, 87% on 26 November, 97% on 3 December and 97% on 12 December 2019. The staff uniform compliance rate during the same period was routinely at or above 97%.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We checked cleaning schedules and noted records were up to date and reflected the various areas of the ED that required cleaning. Staff used ‘I am clean stickers’ to indicate that cleaning had taken place, we noted these were in date and easily visible to staff.

Clean linen was accessible and stored on covered trolleys within the ED. Staff told us that even in busy times they could replenish their linen stock. All the store rooms we observed were clean, tidy and well ordered. Toys held in the children’s emergency department (CHED) waiting areas were routinely cleaned and we checked cleaning rotas that showed staff cleaned these in line with cleaning schedules.

Staff followed infection control principles including the use of personal protective equipment (PPE). The ED did not screen for Methicillin-resistant Staphylococcus aureus (MRSA) or Methicillin-sensitive Staphylococcus aureus (MSSA) within the department. This was done when the patient was admitted onto a ward.

Staff were aware of and practiced infection prevention and control (IPC) in line with national guidance. Handwashing facilities and hand sanitiser stations were readily available throughout the department and the “Five Moments of Hand Hygiene” guidance was displayed at all hand washing stations. Five Moments for Hand Hygiene defines the key moments for hand hygiene, overcoming misleading language and complicated descriptions.

We observed staff following hand hygiene, ‘Bare below the Elbow’ guidance, and wearing PPE such as gloves and aprons whilst delivering care in line with the trust’s policy. The department had a plentiful supply of PPE and we observed staff restocking this as required. The trust had seconded a nurse for 12 months as IPC lead within the ED. We noted the IPC lead within the ED, offering guidance to staff and carrying out IPC audits.
Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff cleaned equipment thoroughly between patients to reduce the risk of cross contamination and restocked equipment where appropriate. The department had dedicated cubicles for patients with a possible infection. All patients were screened as part of their initial assessment to assess whether they had any infections or had visited any overseas locations to ensure the risk of cross infection to patients and staff was minimised. Staff also focused on screening all patients for flu to reduce risks to other patients and staff.

**Environment and equipment**

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

Patients could reach call bells and staff responded quickly when called. Following our last inspection, we raised concerns with the trust regarding the lack of patient call alarm bells in the rapid assessment and treatment (RAT) areas. On our inspection we noted that patient call alarms had been installed in the RAT area and staff ensured these were within reach for patients and families.

The design of the environment followed national guidance. There was a dedicated entrance for ambulance and air ambulance arrivals which led to the resuscitation and RAT areas that enabled critically ill patients to be triaged and transferred to the correct area. Patients self-presenting used the main reception areas for the ED and the ambulatory minor’s area for minor injuries. The main ED entrance was staffed by the reception team 24 hours a day, seven days per week.

The ambulatory minor’s operated between 8am and 11am seven days per week and was staffed by the reception team. Outside of these hours this area was closed, and all patients were redirected to the main ED reception.

Some areas of the ED were covered by internal and external closed-circuit television (CCTV) and access into the ED clinical areas was by swipe card to manage patient and staff safety.

The ChED was accessed by the main hospital corridor, this had CCTV and swipe card access. Reception staff covered reception from 8am to 11pm daily, out of hours access was through a buzzer and CCTV intercom system. The older people emergency department (OPED) and clinical decisions unit (CDU) were accessible by swipe card access and were adjacent to the ChED and main elderly patient care ward.

The layout of the department was appropriate for supporting easy access to diagnostic and imaging services. It provided X-rays for adults and children. Staff were confident that access to computerised tomography (CT) or magnetic resonance imaging (MRI) scans was not delayed when required for urgent investigations. Staff told us that children using these facilities used the same entrance as adult patients. However, patients were always escorted by a member of hospital staff when going for an imaging service.

There were three dedicated rooms within the ED to enable patients with mental health needs to have mental health assessments. All rooms were in line with the Royal College of Emergency Medicine (RCEM) mental health tool kit for improving care in emergency departments. The tool kit states any assessment area needs to be safe for staff, and conducive to valid mental health assessment and importantly, the assessment room must be safe for both the patient and staff. We found staff used these areas for patients with mental health needs as a priority. ED staff did use these rooms as escalation areas during increased times of patient demand. However, staff always considered the needs of patients with mental health as a priority when using the rooms. This was an improvement from our last inspection.
The RAT area had two additional trolleys placed within its reception space. Staff told us they used these during escalation (times of high patient flow within the department) and placed patients onto the trolleys whilst waiting for a bay to become free within the RAT area. The trolleys were in front of emergency resuscitation equipment, outside of a toilet and had no access to call bells. The trolleys were not part of the trust’s escalation plan.

We brought this issue to the attention of the staff who told us that senior medical staff had requested this to improve patient flow into the RAT area and reduce waiting times on ambulances. However, this did not promote patient dignity or safety, the trust removed the trolleys immediately. We noted on our unannounced inspection on 20 December 2019 that the trolleys were no longer in use.

The RAT area had a fit to sit area, with up to ten chairs. Fit to sit is where patients had been assessed by ambulance staff as fit enough to sit in the RAT area whilst waiting to be seen. The number of chairs in this area increased during the day, based on patient flow. We observed a patient deemed fit to sit who deteriorated quickly. Staff struggled to get to the patient or get any emergency equipment to them. We raised this issue to the trust who immediately removed the additional chairs. During our unannounced inspection on the 20 December 2019, the number of seats in the RAT seating area had reduced and safe access was possible.

We checked 20 items of electrical equipment and consumables within the department and found that electrical equipment had been safety tested and serviced appropriately and consumables were in date for use.

Staff did not carry out safety checks of all specialist equipment. Staff had access to adequate supplies of available, accessible and suitable equipment, including resuscitation equipment. Scheduled checks for equipment had been followed and recorded in all areas except the CDU. On the CDU we found the resus trolley had not been checked weekly on the 4, 9 and 25 of November 2019 and 2 December 2019. The CDU trolley was tagged, but none of the draws were locked. This meant the tag had been placed on when the draws were open. We brought this to the attention of the manager on duty during our inspection. On our unannounced inspection on the 20 December 2019, we found the same issue and the resus trolley tagged, but not locked. We checked the resus trolley in the major’s area and found the same issue. We raised this with the nursing director. Staff identified that the tag was not being threaded properly to seal the trolley. Staff took immediate action to deal with this issue, took photographs to explain how to tag the trolley properly and shared this information as part of its organisational wide learning.

The service had suitable facilities to meet the needs of patient’s families. Due to the separation of the adult and ChED, there was clear audio and visual separation between adults and children and appropriate seating and space for children and families to wait. This was an improvement on our last inspection.

The department had dedicated family rooms for families supporting or waiting to see patients. The department had a patient viewing room which had been newly decorated. Staff used this room if a patient died and families wished to see the deceased prior to them being taken to the trust mortuary.

The ED had introduced monthly ‘Handy Man’ walk arounds with ED matron and trust handy man to identify outstanding minor works and then again, the following week to ensure that the works were completed. This was an improvement from our last inspection.

The service had enough suitable equipment to help them to safely care for patients. The service had sufficient equipment specifically for accommodating obese patients, including trolleys, and
wheelchairs. Areas specifically designed to support patients with mental health needs were appropriately designed to ensure patient and staff safety.

Staff disposed of clinical waste safely. The trust had effective systems and processes in place for the segregation and management of clinical and non-clinical waste. Staff had access to sharps bins throughout the department and we found them to be labelled and dated in line with trust policy.

Assessing and responding to patient risk

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

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff completed most risk assessments to maintain and have oversight of patient wellbeing. Risk assessments included patient pressure care, fluid intake, pain scores and mental health. Risk assessments were completed appropriately in all of the records we reviewed.

The triage process for patients with mental health needs had changed. Patients were previously risk assessed as low, medium and high risk. The staff used ‘Screening’ rather than risk assessing. The use of the term ‘screening’ is deemed more appropriate than risk assessment within mental health services. This is because staff screen the persons mental health to identify risks and needs. The screening process enabled staff to screen patients as routine, enhanced or immediate risk. This enabled patients in crisis to feel safe by using appropriate language. For example, staff using ‘immediate risk’, rather than ‘high risk’. This was an improvement from our last inspection.

The ChED had introduced a risk screen for children with learning disabilities or Autism and created staff link roles to improve knowledge in relation to risks associated with this patient group. The ChED staff team had also introduced daily safety huddles three times per shift to share information on patients who may be at increased risk and require additional support or specialist intervention. This was an improvement from our last inspection.

At the time of our inspection the ED did not complete Venous thromboembolism (VTE) assessments. VTE is a condition where a blood clot forms most often in the deep veins of the leg, groin or arm (known as deep vein thrombosis, DVT) and travels in the circulation, lodging in the lungs (known as pulmonary embolism, PE). This was because the electronic prescriptions and medicines administration (EPMA) was not available within the ED and the VTE screening was therefore completed when patients were admitted onto the wards. The trust were aiming to have EPMA rolled out in the ED by March 2020 which would enable them to start VTE screening.

Staff knew about and dealt with any specific risk issues. Patients deemed at higher or immediate risk could be prioritised by staff on the trusts electronic patients record system. This meant they were more likely to be seen as a priority rather than in time or arrival order. This gave staff the opportunity to identify patients most likely to deteriorate or with increased or immediate needs, so they could be seen without additional delays.

Unfortunately, due to the resignation of the trust’s sepsis lead nurse and a gap before a new sepsis nurse started in post, no sepsis audits were conducted in quarter one or quarter two. The trust did start auditing in quarter three, however the data was not available at the time of our inspection. The staff used the daily serious incident group review process to identify episodes where potential lapses in sepsis care occurred and these were subsequently investigated. Managers used the mortality review process to identify cases where there were potential lapses in sepsis care and these were then reviewed at formal structured judgement review meetings.
with the trust’s sepsis lead in attendance.

The sepsis lead clinician and new sepsis lead nurse continued to develop sepsis pathways both for adults and children. The trust have developed links with a local university school of nursing to deliver sepsis education to year three nursing students. Sepsis awareness will be included in induction for new starters from January 2020. At the time of our inspection the trust’s children’s critical care working group were in the process of reviewing, updating and unifying paediatric sepsis pathways to improve compliance.

The trust sepsis lead clinician meets regularly with clinical coding to try and ensure coding of sepsis is accurate across the trust.

The service had 24-hour access to mental health liaison and specialist mental health support. The ED used a standard operating procedure (SOP) for the management of patients requiring specific mental health pathways. The SOP set out roles and responsibilities, timescales for response, communication and documentation, escalation, and reporting processes. The ED had access to psychiatric liaison staff 24 hrs per day, seven days per week based within the hospital. The trust employed a full time matron and two deputy matrons to specifically lead and coordinate mental health services within the ED and liaise with community mental health teams. This was an improvement from our last inspection.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The ED had developed a mental health screening process within its electronic patient record system. This enabled staff to accurately record and monitor patient mental health and wellbeing. The new patient priority rating within the electronic patient record gave staff the opportunity to highlight patients who needed early intervention. Staff could also utilise SAD and suicide assessment tools for patients with mental health conditions and an attendance tracking proforma for tracking patients with mental health needs as they accessed service in the ED. The paediatric teams had a specific screening tool for paediatric mental health within the ChED. This was an improvement from our last inspection.

Shift changes and handovers included all necessary key information to keep patients safe. We observed nursing and medical staff handovers. Handovers focused on the specific needs of individual patients in order to prioritise their care and maintain their safety. Mental health staff were very visible throughout the ED during our inspection, assessing patients and providing guidance to staff.

Staff shared key information to keep patients safe when handing over their care to others. Staff shared detailed information to reduce patient risks and try to support flow throughout the ED. We observed medical staff discussing patients and identifying their care based on clinical priority and the level of risk they presented. Key information in relation to the patient’s condition, for example level of pain, comfort and possible care pathway was shared within the team. Staff were allocated to patients based on their skills and experience to further minimise risks.

Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them appropriately. The trust used the national early warning score system (NEWS). An early warning score is a guide used by medical services to quickly determine the degree of illness of a patient. It is based on the vital signs of respiratory rate, oxygen saturation, temperature, blood pressure, pulse and heart rate. The trust were in the process of combining all of its patient records onto an electronic patient record system. This gave staff the opportunity to review a patient observations and NEWS score from electronic work stations located within the ED areas. This was in its infancy and we found NEWS scores were completed electronically and on the handwritten records we reviewed.

At our last inspection in January 2019, we found the RAT area was a nurse led service with
support from medical staff between 9am to 9pm. Staff we spoke with during our most recent inspection said the lack of medical staff within the RAT area was still evident. This impacted on patient waiting times and decisions to admit or stream patients to alternative services. This was an issue at our last inspection.

The Royal College of Emergency Medicine (RCEM) guidance says that streaming should be performed as soon as possible, ideally be within 15 minutes of the patient’s arrival in the ED, and that all patients attending the ED should be registered within five minutes of arrival. During our inspection we found that the staff routinely registered patients within five minutes of arrival. The ongoing concern of patients being streamed and assessed in a timely fashion was still an issue for the trust and highlighted further at times of high patient demand. At our unannounced inspection on 19 December 2019, we found that patients had been escalated appropriately. The trust cross-site escalation processes were supporting patient flow through the ED and this made a genuine difference to streaming and discharge times.

Following our inspection, the trust told us that on 11th January 2020 the clinical decisions unit (CDU) closed and the trust relocated ambulatory majors to this location. This provided one six cubicle bay for the care and treatment of ambulatory majors patients, and another bay was converted into a waiting room. This increased the number of cubicle spaces for these patients from two to six and increased the size and suitability of the waiting area. It also addressed one of the top five risks on the trusts risk register which related to capacity in ambulatory majors.

The mean performance against the four hour standard for these patients was 33% prior to the move; this increased by 12% to 55%, with ‘special cause’ improvement noted throughout the period since the relocation.

Children were immediately directed to the ChED on arrival. All patients were triaged on arrival and transferred to the area best suited to provide treatment. We reviewed the notes of seven children in relation to CEWS (Children’s Early Warning Score), six children were triaged within fifteen minutes, complying with the standards for children, and young people in emergency care settings set by the Royal College of Paediatrics and Child Health (RCPCH 2012).

Life support training rates were not in line with the trust’s required compliance rates. For example, within the main adult ED medical staff achieved 75% compliance and nursing staff achieved 74% compliance with adult basic life support against the trust target of 90% compliance. Within the ambulatory minor areas medical staff achieved 67% compliance and nursing staff achieved 100% compliance with adult basic life support. Medical staff achieved 65% compliance and nursing staff achieved 72% compliance with paediatric basic life support.

**Emergency Department Survey 2018 – Type 1 A&E departments**

The trust scored about the same as other trusts for all five of the Emergency Department Survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>6.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>7.0</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Q33. In your opinion, how clean was the emergency department?  
<table>
<thead>
<tr>
<th></th>
<th></th>
<th>8.9</th>
<th>About the same as other trusts</th>
</tr>
</thead>
</table>
Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?  
|     |     | 9.6 | About the same as other trusts |

(Source: Emergency Department Survey 2018)

**Median time from arrival to initial assessment (emergency ambulance cases only)**

The trust reported a median time from arrival to initial assessment of zero minutes from September 2018 to July 2019 followed by a median time of 59 minutes in August 2019.

**Ambulance – Time to initial assessment from September 2018 to August 2019 at Norfolk and Norwich University Hospitals NHS Foundation Trust**

(Source: NHS Digital - A&E quality indicators)

**Percentage of ambulance journeys with turnaround times over 30 minutes for this trust**

Norfolk and Norwich University Hospital

The percentage of ambulance journeys with turnaround times over 30 minutes at the trust ranged from 49.2% in May 2019 to 75.1% in January 2019. In the most recent month, August 2019, 65.2% of ambulance journeys had turnaround times over 30 minutes.

**Ambulance: Number of journeys with turnaround times over 30 minutes - Norfolk & Norwich University Hospital**

**Ambulance: Percentage of journeys with turnaround times over 30 minutes - Norfolk & Norwich University Hospital**
A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.

From July 2018* to July 2019 the trust reported 3,819 “black breaches”, with a varied trend over the period.

Numbers increased to above the overall average over the winter period from November 2018 to February 2019. The highest number of black breaches (818) was reported in December 2018. The number of black breaches decreased to below the overall average from March to July 2019.

The trust stated that the core themes from the incidents included:

- Poor flow out of the emergency department.
- Delays in senior decision making due to workforce constraints.
- The inability to open escalation corridor due to nursing shortfalls.
- High volumes of activity for both ambulances and emergency department attendances.
- Mental health breaches
At our last inspection the ED had no specific guidance for managing patients waiting on ambulances or identifying patients most likely to deteriorate. The trust was issued a section 29a warning notice in relation to this specific issue and responded by putting in place a standard operating procedure (SOP) to increase the oversight of patients and identify patients most likely to deteriorate.

During our inspection we found that the SoP was not in use on all occasions. We immediately escalated our concerns. Following this staff routinely escalated patients waiting on ambulances in line with its SOP and that medical staff assessed patients based on their clinical priority. The medical staff were meant to record this intervention within patient written records by using a yellow sticker. However, staff told us this was not always done due to the demands within the department. We checked three records of patients who were waiting on ambulances longer than one hour and found the sticker was not used.

**Nurse staffing**

The service had enough nursing and support staff to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

**Trust level**

The table below shows a summary of the nursing staffing metrics in urgent and emergency care at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>August 2018 to July 2019</th>
<th>July 2018 to June 2019</th>
<th>April to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual average establishment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual vacancy rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual turnover rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual sickness rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual bank hours (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual agency hours (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual unfilled hours (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* please note this is a partial month

(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)
<table>
<thead>
<tr>
<th>Target</th>
<th>All staff</th>
<th>10%</th>
<th>10%</th>
<th>4.0%</th>
<th>of available hours</th>
<th>28%</th>
<th>16%</th>
<th>5.4%</th>
<th>of available hours</th>
<th>of available hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nurses</td>
<td>450</td>
<td>23%</td>
<td>4.6%</td>
<td>9,241 (7%)</td>
<td>10,491 (8%)</td>
<td>15,536 (11%)</td>
<td>217</td>
<td>17%</td>
<td>10%</td>
<td>4.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

The trust only provided data on bank use and agency use for four months and therefore analysis of change over time was not possible.

**Vacancy rates**

![Vacancy rate chart](chart)

Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives showed a downward trend from October 2018 to March 2019 followed by an upward trend from March 2019 to July 2019.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

![Turnover rate chart](chart)

Monthly turnover rates over the last 12 months for qualified nurses, health visitors and midwives showed a downward trend from September 2018 to January 2019 followed by an upward trend.
from January 2019 to May 2019.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

![Sickness rate - qualified nurses, health visitors and midwives](image)

Monthly sickness rates over the last 12 months for qualified nurses, health visitors and midwives showed a downward trend from December 2018 to June 2019.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Norfolk and Norwich University Hospital**

The service had enough nursing and support staff to keep patients safe.

The table below shows a summary of the nursing staffing metrics in urgent and emergency care at Norfolk and Norwich University Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>August 2018 to July 2019</th>
<th>July 2018 to June 2019</th>
<th>April to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Annual average establishment</td>
<td>Annual vacancy rate</td>
<td>Annual turnover rate</td>
</tr>
<tr>
<td>Target</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>437</td>
<td>28%</td>
<td>16%</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>209</td>
<td>24%</td>
<td>17%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

The ward manager could adjust staffing levels daily according to the needs of patients. Managers discussed staffing levels at each staff handover and throughout the day at safety
huddles. Managers used safer staffing tools to identify patient need and areas of the department that required additional staff, for example if a patient required one-to-one support.

The number of nurses and healthcare assistants matched the planned numbers. The trust had been successful in its recruitment processes and vacancies had significantly reduced. The ED matron and nurse director held twice weekly roster 'look ahead meetings' to plan staffing rotas and ensure cover was in pace to fill any gaps. This was an improvement from our last inspection.

The recruitment brought additional challenges involving junior staff and skill mix. Managers delegated staff to areas where they had completed their required competencies. The practice development nurse explained how they were working with the managers to increase staff competencies and skills to enable staff to work across all areas of the ED.

The trust met the Royal College of Paediatrics and Child Health (RCPCH) standard of having two registered children's nurses on every shift. The trust had also recruited a children’s matron as part of its ED management team. This role was highly valued by the staff team who said it had brought continuity and leadership to the department. This was an improvement from our last inspection.

Following our inspection, the trust told us they increased the intake of newly-qualified nurses and successfully recruited experienced nurses from other organisations and overseas. This reduced the vacancy rate from 46 whole time equivalents (WTE) in May 2019 to 13 WTE in January 2020. Additional recruitment was underway with plans to appoint an extra 6.5 WTE Band 6 nurses and the remaining vacancies filled by the end of April 2020.

The ChED had a dedicated play team covering 12 hours shifts six days a week. The play team supported children in the ChED to offer diversion techniques for treatment, reassurance and to provide additional to support to the duty team. This was an improvement from our last inspection.

The trust only provided data on bank use and agency use for four months and therefore analysis of change over time was not possible.

**Vacancy rates**

The service had reducing vacancy rates. The trust had successfully recruited to posts within the ED and this reduced the overall vacancy rates.

![Vacancy rate chart](chart.png)

Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives showed a downward trend from October 2018 to March 2019 followed by an upward trend from...
March 2019 to July 2019.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

The service had low and reducing turnover rates. Managers we spoke with were focused on reducing staff turnover rates and actively encouraging new staff to feedback on their experiences within the department to make improvements to increase staff retention.

![Turnover rate - qualified nurses, health visitors and midwives](image)

Monthly turnover rates over the last 12 months for qualified nurses, health visitors and midwives showed a downward trend from September 2018 to January 2019 followed by an upward trend from January 2019 to May 2019.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

The service had low and reducing sickness rates. Managers we spoke with said the successful recruitment process had reduced sickness rates within the department. At the time of our inspection we identified staffing levels within the ED fell below expected numbers due to staff sickness. The managers worked closely to provide additional staffing and used agency / bank staff to fill any gaps in the service.

Following our inspection, the trust told us that sickness levels have reduced from 7.3% in July 2019 to 4.4% in January 2020.
Monthly sickness rates over the last 12 months for qualified nurses, health visitors and midwives showed a downward trend from December 2018 to June 2019.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Medical staffing

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

Trust wide

The trust did not allocate medical staff specifically to Cromer Hospital, medical staff are shared between the two sites.

The table below shows a summary of the medical staffing metrics in urgent and emergency care at the trust compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Urgent and emergency care annual staffing metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>August to July 2019</td>
</tr>
<tr>
<td></td>
<td>Annual average establishment</td>
</tr>
<tr>
<td>Target</td>
<td>450</td>
</tr>
<tr>
<td>All staff</td>
<td>79</td>
</tr>
<tr>
<td>Medical staff</td>
<td>10%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)
Medical staffing rates within urgent and emergency care were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover. The trust only provided data on bank use and locum use for four months and therefore analysis of change over time was not possible.

The trust provided an ED consultant in the department from 8am to 12am seven days per week and ED consultant on-call from 12am to 8am which met the 16 hours consultant cover per day recommended by the Royal College of Emergency Medicine (RCEM). Consultant medical staff managed care throughout the department as needed and one consultant acted as the emergency physician in charge of services.

We observed a medical staff handover where staff discussed key issues in relation to patient needs and safety as well as patient flow through the department and bed allocation across the trust. Staff used this time as an opportunity for the emergency physician in charge to challenge staff on patient needs, condition management and to deliver bite size learning sessions.

Between July 2018 and June 2019, the children’s emergency department saw 24,868 patients that were less than 17 years of age. The RCEM recommends that emergency departments seeing more than 16,000 children per year should have at least one paediatric emergency consultant. The trust provided 24-hour paediatric consultant cover through an on-call rota and met the RCEM standard.

Vacancy rates

The service had reducing vacancy rates for medical staff. Managers we spoke with during the inspection told us that recruitment was ongoing to increase the number of medical staff within the ED. The trust has been successful in its recruitment of overseas medical staff which included seven middle grades over the last nine months. The trust had clear plans to increase the number of medical staff within the ED over the next 12 months.

![Vacancy rate - medical staff](image)

Monthly vacancy rates over the last 12 months for medical staff showed a shift from February 2019 to July 2019.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Following our inspection, the trust told us it had reviewed consultant job descriptions within the ED to increase the number of potential candidates attracted to the role. The trust recognised that there was a lack of ED consultants trained nationally for the number of posts required, therefore creating new roles with a better work-life balance may attract more staff. This trust created consultant posts with a leadership role for a range of special interests, such as research and
development, quality improvement, mental health, same day emergency care, and university teaching. The trust were keen to attract doctors who were enthusiastic and keen to further the development of the ED in the future.

**Sickness rates**

The service had increased sickness rates for medical staff. The trust had a number of wellbeing strategies to try and reduce staff sickness rates. These included a wellbeing box containing healthy snacks within the ED to ensure medical staff had access to nutrition during their shift. The medical staff had a self-planned working rota to enable them to manage on duty and off duty times. Managers we spoke with said this enabled medical staff to plan around family and caring duties. This encouraged staff to work at times which were beneficial to them but also enabled the trust to maintain an effective medical staff rota.

![Sickness rate - medical staff](image)

Monthly sickness rates over the last 12 months for medical staff showed an upward trend from August 2018 to December 2018.

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

**Staffing skill mix**

The service did not have a good skill mix of medical staff.

In June 2019, 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 lower.

**Staffing skill mix for the 45 whole time equivalent staff working in urgent and emergency care at Norfolk and Norwich University Hospitals NHS Foundation Trust.**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>45%</td>
<td>30%</td>
</tr>
</tbody>
</table>
| Middle career^
                       | 8%         | 15%             |
| Registrar group~     | 31%        | 33%             |
| Junior*              | 16%        | 21%             |
At our inspection in January 2019, managers and staff told us the medical staff skill mix meant there was a lack of senior clinical decision makers across the ED. During our recent inspection this issue was still evident and impacted on patient flow, meaning patients waited longer periods to be seen. The trust was actively recruiting to fill vacancies, to improve the skill mix and reduce reliance on locums.

**Records**

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

Patient notes were not always comprehensive. At the time of our inspection, the trust were moving towards paperless patient record systems. As a result, the service used a blend of paper and electronic patient record systems. Staff we spoke with felt confident in using the systems.

We reviewed 34 sets of patient records, including seven in relation to children. All the records we reviewed contained details of patients’ presenting conditions, medical history, allergies and current medication. Details of their general practitioner (GP) and next of kin were also recorded where necessary. Risk assessments were fully completed in all the records we reviewed.

When patients transferred to a new team, there were no delays in staff accessing their records. Information required to deliver care was available in a timely manner, for example referring patients for X-rays and blood results. Information required for ongoing care was shared appropriately when patients moved between services.

Records were stored securely. A great deal of the patients’ records were computer based, this required a password entry to reduce the risk of unauthorised access to patient details. Where patient records were in open tray systems, staff used a sign on top of the patients record saying confidential, to cover all of the patient details and any records below.

**Medicines**

**The service did not use systems to record and store medicines safely.**

Staff did not follow systems and processes when recording and storing medicines. In the adult ED we found a range of medication outside of their original boxes all held in a plastic cup. These included blisters of tablets. Some medications appeared to have been dispensed for patients but were used as stock, there was no tracking to say if the patient had left or returned to the ED.
These medicines were not formalised stock and contained a range of medicines from antibiotics to benzodiazepines.

Staff did not store and manage all medicines in line with the provider’s policy. On the OPED we found a box of medication that contained two different batches of the same medication with different expiry dates, which if not checked could have led to out-of-date medication being used. We also found a number of medications that were past their expiry date, stored in the medication cupboards. The trust policy states these should be checked monthly, we found no record of recent checks taking place.

Staff did not routinely maintain records of ambient room temperatures and refrigeration temperatures. In the ChED we found gaps in the recording of ambient temperatures every month between February and November 2019. We found gaps in refrigeration temperatures in February, March, April and May 2019. The refrigerator in the adult ED was overloaded with stock. Stock was touching the sides and back plates of the refrigerator giving no circulation of cold air.

We found three sets of liquid medication opened, with no date of opening recorded which meant we were unsure if the medication was still within its safe use date.

The controlled drugs (CD) cabinet was locked within a locked room, but controlled drugs cabinet door locking system was not secure this did not comply with the Misuse of Drugs Act (1973) Safe Custody. We also found medication had spilled within the cabinet, leaving a distinctive residue that had not been cleaned for a long time. We found numerous entries within the CD register where staff had crossed out or written over entries or made entries illegible. However, all stocks of CD in the main ED did tally and were accounted for.

On the OPED the CD cupboard was made of wood and had an inappropriate lock this did not comply with the Misuse of Drugs Act (1973) Safe Custody. The CD cabinet also had patients own medication stored within it, these were not clearly marked and on the same shelves as the ward stock. CD checks were not being completed daily and several days were missing. And there were numerous occasions where staff had crossed out entries in the CD book.

We reviewed an incident reported by staff within the trust, where no CD checks had been carried out on the OPED for five days and the checks on the sixth day revealed a shortage of a particular medication. This demonstrated that the staff were not carrying out medication checks in line with the trust policy.

We found one box of medication labelled as 500 microgram nebulae, however the box contained both 500 microgram and 250 microgram nebulae. We found another pack of nebulae opened with no date of opening on the foil pack. These nebulae once opened were only suitable for use on the 3 December 2019, we found these open in the CD cabinet on the 10 December 2019.

Staff reviewed patient’s medicines regularly and provided specific advice to patients and carers about their medicines. We reviewed 34 patient records, records demonstrated that staff gave medication where appropriate, including pain relief in a timely fashion.

Staff followed current national practice to check patients had the correct medicines. Staff followed the trust policy on the administration of medication. Posters were on display around the department advising staff of best practice in the administration of medicines, including the ten ‘R’s of safe multidisciplinary drug administration. We observed staff checking patient wristbands prior to administering medication and using patient records to accurately record medications given. The trust had specific guidance on the use of patient group directions (PGD’s). The trusts guidance on PGD’s was clear in terms of which staff could and could not use PGD’s in their everyday practice in order to meet individual patients needs. This met NICE guideline MPG2 (2017) Patient Group
Directions which states that the majority of clinical care should be provided on an individual, patient-specific basis.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. All areas of the ED held green staff folders that contained up-to-date information in relation to the department. This included updates and safety alerts on medicines. Meeting records showed that medication, and incidents were discussed with staff and safety alerts were sent via email, discussed at safety huddles and shared in the ED newsletter.

Decision making processes were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines. Staff we spoke with during the inspection understood the use of capacity and consent in order to understand and meet the needs of patients. Medications were regularly reviewed and agreed with medical oversight to ensure that medicines were only given in line with the trusts policy and not used to inappropriately sedate patients.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff we spoke with during our inspection were clear on the need to report incidents and near misses appropriately. All staff knew the trust had an incident reporting policy and understood the process for submitting an electronic incident notification.

Never events

The service had three never events within the ED. Staff raised concerns and reported incidents and near misses in line with trust policy. 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.

From October 2018 to December 2019, the trust reported three never events for urgent and emergency care.

The incidents took place on 14 July 2019, and the 19 and 25 November 2019 involving the unintentional connection of a patient requiring oxygen to an air flowmeter.

(Source: Strategic Executive Information System (STEIS))

Managers shared learning about never events with their staff and across the trust. During our inspection we spoke to staff, all of whom knew about the never events and the actions taken by the trust to minimise these happening again.

There was evidence that changes had been made as a result of feedback. Staff kept air flowmeters unattached in designated areas within the ED until they were required to reduce the possibility of wrong connections happening.

Managers shared learning with their staff about never events that happened elsewhere.
Information in relation to never events was shared through safety huddles, emails and ED newsletters as well as safety notices across the trust.

**Breakdown of serious incidents reported to STEIS**

Staff reported serious incidents clearly and in line with trust policy. All staff we spoke with knew how to report incidents and how to follow the trusts incident reporting policy.

**Trust level**

In accordance with the Serious Incident Framework 2015, the trust reported 77 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from October 2018 to September 2019.

A breakdown of the incident types reported is in the table below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioning incident meeting SI criteria</td>
<td>53</td>
<td>68.8%</td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>10</td>
<td>13.0%</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient meeting SI criteria</td>
<td>6</td>
<td>7.8%</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI criteria (including failure to act on test results)</td>
<td>3</td>
<td>3.9%</td>
</tr>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>1</td>
<td>1.3%</td>
</tr>
<tr>
<td>Medication incident meeting SI criteria</td>
<td>1</td>
<td>1.3%</td>
</tr>
<tr>
<td>Medical equipment/ devices/disposables incident meeting SI criteria</td>
<td>1</td>
<td>1.3%</td>
</tr>
<tr>
<td>Abuse/alleged abuse of adult patient by staff</td>
<td>1</td>
<td>1.3%</td>
</tr>
<tr>
<td>Failure to obtain appropriate bed for child who needed it</td>
<td>1</td>
<td>1.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>77</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff understood duty of candour and how to apply this following an incident. Managers we spoke with explained how honesty and transparency were important as this helped the trust learn when things went wrong. We reviewed three serious incident reports and found these referenced duty of candour and patients and families were informed when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff could request individual feedback on incidents at the time they completed the electronic incident notification. Information regarding incidents was shared at safety huddles, via emails, team meetings and newsletters. The trust had an intranet which could be used to share information and screen savers were used to highlight changes in practice or current concerns.

Staff met to discuss the feedback and look at improvements to patient care. Safety huddles were a key method of sharing information from incidents. Staff from different areas of the ED and roles met during the handovers which encouraged shared learning within the department. Staff were encouraged to attend safety huddles and to actively be involved in sharing learning and challenging practices within the ED.

Managers investigated incidents thoroughly. Patients and their families were involved in these
investigations. Learning from incidents was shared through the trust’s divisional governance processes, reporting via the clinical safety and effectiveness sub board and organisational wide learning (OWL). We reviewed three serious incident reports and found these had been investigated thoroughly with a route cause analysis and recommendations for improvements to minimise further incidents.

The trust multi-professional essential care scrutiny panel reviewed all cases of harm. The serious incident group (SIG) met daily to discuss incidents reported within the previous 24 hours. This was a multidisciplinary staff group that met to discuss the level of patient harm, share learning from incidents, identify recurring themes and any system failures. The SIG generated safety alerts and collated case studies for sharing via the trust’s ‘Sharing the learning’ e-bulletin.

The trust established a mental health board with a senior staff lead responsible for mental health across the trust, this board reviewed incidents in relation to any patient with mental health needs. The board met with partners to look at ways to improve care pathways for patients with mental health needs who accessed acute care services. The mental health board activities were scrutinised by the clinical safety and effectiveness sub board for assurance.

The trust carried out monthly look back assurance exercises to review all actions associated with serious incidents have been completed. Outcomes from the reviews were reported to quality and safety committee who escalated any actions not completed.

Managers debriefed and supported staff after any serious incident. Following the never events, the trust ensured all appropriate staff involved in these events were debriefed and offered appropriate support.

**Safety thermometer**

**The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, women and visitors.**

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.

Staff used the perfect ward system to record any safety data to further improve services. Information from the perfect ward was displayed on notice boards in key areas within the department for patients, relatives and staff to see.

Data collection 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 the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported one new pressure ulcer, nine falls with harm and 16 new urinary tract infections in patients with a catheter from September 2018 to September 2019 within urgent and emergency care.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at Norfolk and Norwich University Hospitals NHS Foundation Trust**
1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital - Safety Thermometer)
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients’ subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff could access local policies, guidelines and procedures on the trust’s intranet. Guidance for staff was placed next to work stations so staff could quickly find them, for example standards around sepsis, delirium and resuscitation.

National Institute for Health and Care Excellence (NICE) guidance was available throughout the department and on the trust intranet. We noted staff referring to NICE guidance (CG103) Delirium: prevention, diagnosis and management Clinical guideline (March 2019) when supporting a confused patient. The trust had an up-to-date policy to support the implementation of new guidance across the departments.

We reviewed a number of policies and pathways on the trusts intranet, for example safeguarding adults and children, delirium, head injury guidance, sepsis and stroke. These were up-to-date and referred to national and local guidance.

Staff protected the rights of patients’ subject to the Mental Health Act and followed the Code of Practice. Staff we spoke with were more confident supporting patients with mental health needs. For example, staff had recognised the importance of language and terminology in relation to patients with mental health needs and moved away from using “Risk Assessments” to “Risk Screening”. Staff had also updated the patient pathway for patients with mental health. The triage process had changed from low, medium and high to routine, enhanced and immediate. The language had changed to make people in crisis feel safe by using appropriate language, such as ‘immediate risk’, instead of ‘high risk’. The use of the term ‘screening’ is more appropriate than assessment, as it is a screen of the persons mental health to identify risks and needs.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We observed handovers and found that staff routinely discussed patients with additional psychological and emotional needs to highlight any ongoing risks or seek additional support. Staff could prioritise patients on the trust’s electronic patient record system and used an electronic flag to identify patients with additional needs, for example dementia or a learning disability.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff reviewed patient’s nutrition and hydration needs following the initial triage assessment. If it was safe for patients to eat and drink, staff offered food and drink to meet their needs. Staff had recently worked with the catering team to provide patients with a warm meal if they had been in the department for extended periods, or if this was necessary to maintain the patient’s wellbeing.

Patients we spoke with told us they had been offered food and drink whilst in the department.
The ED had a range of vending and drinks machines in its reception area as well as access to fresh drinking water. A patient told us they had asked for some breakfast and been given a cup of tea and a slice of toast. In the children’s emergency department (ChED) patients were offered snack lunch boxes where safe to do so, to provide nutrition hydration. This was an improvement from our last inspection.

Staff fully and accurately completed patient’s fluid and nutrition charts where needed. The paper-based patient record enabled staff to record initial fluid intake and carry out fluid observations for any patients felt to be at risk of fluid retention or dehydration.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. If a patient was transferred to a longer stay ward within the trust or stayed longer than 12 hours within the ED staff would use the malnutrition universal screening tool (MUST) as they would be observing the patient over longer periods. At the time of our inspection none of the patients were using the MUST, but staff understood how to implement this process.

**Emergency Department Survey 2018 – Type 1 A&E departments**

In the CQC Emergency Department Survey, the trust scored 7.5 for the question “Were you able to get suitable food or drinks when you were in the emergency department?”. This was about the same as other trusts.

(Source: Emergency Department Survey 2018)

**Pain relief**

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

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff monitored patients’ pain using pain assessment tools. They had a visual chart ranging from zero to ten, zero being the least pain with a happy face and ten the worst the pain could be with a very sad face. This was useful to use for children and patients with learning disabilities or for those with impaired communication or cognitive impairment.

Staff prescribed, administered and recorded pain relief accurately. We reviewed 34 patient records including seven in relation to children and found medication records up to date and reflecting the patient’s needs.

Patients received pain relief soon after requesting it. Where appropriate patients were given pain relief on time and pain level were reviewed to establish if the patient required any additional pain relief or alternative treatments.

**Emergency Department Survey 2018 – Type 1 A&E departments**

The trust scored 7.4 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was the about same as other trusts.

(Source: Emergency Department Survey 2018)

**Patient outcomes**

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
The service participated in relevant national clinical audits. The provider offered some updates in relation to actions it had taken in relation to national audits. Action plans were comprehensive and aimed to drive performance and improve services for patients.

Outcomes for patients were positive, consistent and met expectations, such as national standards. Audit data showed that the trust required improvement in a number of areas, in order to achieve better outcomes for its patients.

Managers and staff used audit results to improve patient outcomes. Managers that we spoke with knew what audits the ED was engaged with and how the teams were monitoring performance to drive improvement.

Managers shared and made sure staff understood information from the audits. Local and national audit data was available for staff within the ED and we noted in governance and team meeting records managers shared audit data and patient outcomes with the staff teams. Audit results, for example 2016/17 RCEM severe sepsis and septic shock were used to develop action plans and improve treatment times.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The trust used a performance dash board to share key performance data and audit outcomes across the various divisions. The perfect ward round data was shared with all ED staff and action plans were in place to address any shortfalls in compliance, for example, infection, prevention and control compliance.

**RCEM Audit: Moderate and acute severe asthma 2016/17**

**Norfolk and Norwich University Hospital**

The table below summarises Norfolk and Norwich University Hospital’s performance in the 2016/17 RCEM moderate and acute severe asthma audit.

The audit reports hospital performance in quartiles. In this context, ‘similar’ means that the hospital’s performance fell within the middle 50% of results nationally.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other Hospitals</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard 1a: O2 should be given on arrival to maintain sats 94-98%.</td>
<td>92.9%</td>
<td>Better</td>
<td>Not met</td>
</tr>
<tr>
<td>Standard 2a: Vital signs should be measured and recorded on arrival at the emergency department.</td>
<td>69.1%</td>
<td>Better</td>
<td>Not met</td>
</tr>
<tr>
<td>Standard 3: High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department.</td>
<td>35.7%</td>
<td>Similar</td>
<td>Not met</td>
</tr>
<tr>
<td>Standard 4: Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy.</td>
<td>77.8%</td>
<td>Similar</td>
<td>Not met</td>
</tr>
<tr>
<td>Standard 5a: If not already given before arrival to the emergency department, steroids given within 60 minutes of arrival (acute severe).</td>
<td>26.3%</td>
<td>Similar</td>
<td>Not met</td>
</tr>
</tbody>
</table>
Standard 5b:
If not already given before arrival to the emergency department, steroids given within four hours of arrival (moderate).

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>56.5%</td>
<td>Better</td>
<td></td>
<td>Not met</td>
</tr>
</tbody>
</table>

Standard 9:
Discharged patients should have oral prednisolone prescribed according to guidelines.

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>45.5%</td>
<td>Similar</td>
<td></td>
<td>Not met</td>
</tr>
</tbody>
</table>

(Source: Royal College of Emergency Medicine)

Improvement was checked and monitored. The trust provided a December 2019 update based on its action plan from the 2015/16 vital signs audit. This showed the trust had responded to the audit and made further improvements. However, many of the actions contained in the action plan had been superseded by the trust’s response to the trust’s RCEM Feverish Child National quality improvement plan 2018/19. The action plan had clear actions and timeframes to improve performance against the standards.

RCEM Audit: Consultant sign-off 2016/17

Norfolk and Norwich University Hospital

The table below summarises Norfolk and Norwich University Hospital’s performance in the 2016/17 RCEM consultant sign-off audit.

The audit reports hospital performance in quartiles. In this context, 'similar' means that the hospital’s performance fell within the middle 50% of results nationally.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients from high-risk groups reviewed by a consultant in Emergency Medicine prior to discharge from the Emergency Department:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atraumatic chest pain in patients aged 30 years and over.</td>
<td>18.5%</td>
<td>Similar</td>
<td>Not met</td>
</tr>
<tr>
<td>Fever in children under 1 year of age.</td>
<td>20.0%</td>
<td>Similar</td>
<td>Not met</td>
</tr>
<tr>
<td>Patients making an unscheduled return to the ED with the same condition within 72 hours of discharge.</td>
<td>15.3%</td>
<td>Similar</td>
<td>Not met</td>
</tr>
<tr>
<td>Abdominal pain in patients aged 70 years and over.</td>
<td>18.2%</td>
<td>Similar</td>
<td>Not met</td>
</tr>
</tbody>
</table>

(Source: Royal College of Emergency Medicine)

The trust had added the RCEM consultant sign-off audit to the 2020/21 ED audit plan to review compliance to standards with previous national audit results. No additional updates were provided by the trust following inspection.

RCEM Audit: Severe sepsis and septic shock 2016/17

Norfolk and Norwich University Hospital

The table below summarises Norfolk and Norwich University Hospital’s performance in the 2016/17 RCEM severe sepsis and septic shock audit.
The audit reports hospital performance in quartiles. In this context, ‘similar’ means that the hospital’s performance fell within the middle 50% of results nationally.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other Hospitals</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard 1</strong>: Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival.</td>
<td>96.0%</td>
<td>Better</td>
<td>Not met</td>
</tr>
<tr>
<td><strong>Standard 2</strong>: Review by a senior (ST4+ or equivalent) ED medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED.</td>
<td>98.0%</td>
<td>Better</td>
<td>Not met</td>
</tr>
<tr>
<td><strong>Standard 3</strong>: O2 was initiated to maintain SaO2&gt;94% (unless there is a documented reason not to):Within one hour of arrival.</td>
<td>59.2%</td>
<td>Better</td>
<td>Not met</td>
</tr>
<tr>
<td><strong>Standard 4</strong>: Serum lactate measured: Within one hour of arrival.</td>
<td>66.0%</td>
<td>Similar</td>
<td>Not met</td>
</tr>
<tr>
<td><strong>Standard 5</strong>: Blood cultures obtained: Within one hour of arrival.</td>
<td>52.0%</td>
<td>Similar</td>
<td>Not met</td>
</tr>
<tr>
<td><strong>Standard 6</strong>: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given: Within one hour of arrival.</td>
<td>50.0%</td>
<td>Similar</td>
<td>Not met</td>
</tr>
<tr>
<td><strong>Standard 7</strong>: Antibiotics administered: Within one hour of arrival.</td>
<td>44.0%</td>
<td>Similar</td>
<td>Not met</td>
</tr>
<tr>
<td><strong>Standard 8</strong>: Urine output measurement/fluid balance chart instituted within four hours of arrival.</td>
<td>24.5%</td>
<td>Similar</td>
<td>Not met</td>
</tr>
</tbody>
</table>

(Source: Royal College of Emergency Medicine)

We asked the trust for an update in relation to the 2016/17 RCEM severe sepsis and septic shock audit. The trust told us it was undertaking a quality improvement project to improve time to antibiotics for patients with suspected sepsis in ED. The report was due to be published in March 2020 and was not available at the time of our inspection.

**Trauma Audit and Research Network (TARN)**

**Norfolk and Norwich University Hospital**

The table below summarises Norfolk and Norwich University Hospital’s performance in the 2018 Trauma Audit and Research Network audit. The TARN audit captures any patient who is admitted to a nonmedical ward or transferred out to another hospital (e.g. for specialist care) whose initial complaint was trauma (including shootings, stabblings, falls, vehicle or sporting accidents, fires or assaults).

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit Rating</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case Ascertainment (Proportion of eligible cases reported to TARN compared against Hospital)</strong></td>
<td>88.7 – 98.5%</td>
<td>Good</td>
<td>Met</td>
</tr>
<tr>
<td>Episode Statistics data</td>
<td>Crude median time from arrival to CT scan of the head for patients with traumatic brain injury <em>(Prompt diagnosis of the severity of traumatic brain injury from a CT scan is critical to allowing appropriate treatment which minimises further brain injury.)</em></td>
<td>62.0 mins</td>
<td>Takes longer than the TARN aggregate</td>
</tr>
<tr>
<td>-------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
<td>------------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>Crude proportion of eligible patients receiving Tranexamic Acid within 3 hours of injury <em>(Prompt administration of tranexamic acid has been shown to significantly reduce the risk of death when given to trauma patients who are bleeding)</em></td>
<td>53.8%</td>
<td>Lower than the TARN aggregate</td>
<td>n/a</td>
</tr>
<tr>
<td>Crude proportion of patients with severe open lower limb fracture receiving appropriately timed urgent and emergency care <em>(Outcomes for this serious type of injury are optimised when urgent and emergency care is carried out in a timely fashion by appropriately trained specialists.)</em></td>
<td>15.4%</td>
<td>Lower than the TARN aggregate</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Risk-adjusted in-hospital survival rate following injury <em>(This metric uses case-mix adjustment to ensure that hospitals dealing with sicker patients are compared fairly against those with a less complex case mix.)</em></td>
<td>0.2 additional deaths</td>
<td>Similar to expected</td>
<td>Did not meet</td>
</tr>
</tbody>
</table>

The trust discussed TARN data at its trauma committee and reported outcomes to the clinical effectiveness and clinical standards group. The trust had detailed action plans in response to any areas for development and worked with other providers to improve patient outcomes across the east of England Trauma Network.

**Unplanned re-attendance rate within seven days**

The service had a lower than expected risk of reattendance than the England average. Staff spoke with understood the importance of patients reattending the ED and worked with additional multidisciplinary (MDT) staff to identify any underlying reasons for reattendance and avoid readmission where possible. The older persons emergency department (OPED) worked closely with the elderly patient teams and MDT to identify patients at risk of reattendance and liaised closely with the community teams to reduce patient readmission.

From September 2018 to August 2019, the trust's unplanned re-attendance rate to A&E within seven days was generally higher than the national standard of 5% and consistently lower than the England average.

**Unplanned re-attendance rate within seven days - Norfolk and Norwich University Hospitals NHS Foundation Trust**
(Source: NHS Digital – A&E quality indicators)

Competent staff

Managers appraised staff’s work performance or held supervision meetings.

Appraisal rates

From April 2018 to March 2019, 60.8% of staff within urgent and emergency care department at the trust received an appraisal compared to a trust target of 85%.

Trust level

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
<th></th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
<td>Eligible staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical and dental</td>
<td>35</td>
<td>41</td>
<td>85.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>28</td>
<td>37</td>
<td>75.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>29</td>
<td>51</td>
<td>56.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>72</td>
<td>138</td>
<td>52.2%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Estates and ancillary</td>
<td>2</td>
<td>5</td>
<td>40.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>166</td>
<td>273</td>
<td>60.8%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Norfolk and Norwich University Hospital

From April 2018 to March 2019, 61.4% of staff within urgent and emergency care department at Norfolk and Norwich University Hospital received an appraisal compared to a trust target of 85%.

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<td>28</td>
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<td>2</td>
<td>5</td>
<td>40.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>69</td>
<td>131</td>
<td>52.7%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
Managers supported nursing and medical staff to develop through regular, constructive clinical supervision of their work. Following our inspection, we asked the trust for additional data regarding appraisal compliance. Data provided by the trust showed that appraisal rates for the nursing teams ranged between 85% and 100% and the medical team compliance was 97%. All of which were equal to or above the trust compliance target.

The trust employed a practice development nurse who supported the learning and development needs of staff within the ED.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend. Managers we spoke with told us they encouraged staff to attend team meetings and to read meeting records when staff were not available for meetings. Staff we spoke with were confident in asking managers for updates on their work performance. Managers informed us that the nurse recruitment process in the ED had affected the ability to complete staff appraisals. Now the staff team was more stable the managers had a plan to complete all appraisals on time.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. We spoke with staff that had received an appraisal within the last twelve months. Staff told us that managers discussed training needs during their appraisal and offered opportunities to develop their skills and knowledge. The nursing director had an open house session every Thursday afternoon, where staff could drop in and discuss their training and development needs. Staff we spoke with valued this opportunity and said the nursing director was extremely supportive of additional training and skills development. The ED also had monthly nursing ‘Career Clinic’ drop in session with nurse director, ED matron and ED education team. This was an improvement from our last inspection.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff we spoke with who had received appraisals told us that managers identified any training needs and gave them the time and opportunity to develop their skills and knowledge.

Managers gave all new staff a full induction tailored to their role before they started work. New staff entering the department completed a dedicated competency framework based on Royal College of Nursing Competencies. The practice development nurse supported the learning and development needs of staff and actively worked alongside managers to provide training and development opportunities. All newly qualified nurses completed an eight week induction programme which included the trust welcome pack and detailed information to orientate them into the department.

Managers made sure staff received any specialist training for their role. Managers actively sought to provide additional training for staff to improve their skills and experience.

Staff were qualified and had the right skills and knowledge to meet the needs of patients. However, managers knew they had a junior work force and the skill mix had changed during the recruitment process due to a number of experienced staff leaving the department. Staff gave examples of requesting additional training, for example a minor injuries course and additional resuscitation training.

Managers identified poor staff performance promptly and supported staff to improve. Managers we spoke with explained how they used the trust’s performance processes to identify anyone who may not be meeting the required standards within their role. Managers had a range of options...
including occupational health and wellbeing activities to support staff who may have performance issues.

**Multidisciplinary working**

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The ED had access to a wide range of multidisciplinary staff within the department. During our inspection we spoke with physiotherapy staff, occupational therapy staff and mental health. Staff were positive about their relationships with the ED teams and explained how they worked together to improve patient outcomes. This was especially evident on the OPED who used links with community based staff and resources to coordinate patient care and where possible speed up safe discharge.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff recognised the importance of MDT working and knew how to access the MDT to benefit patient care. The MDT had a significant presence within the ED and we noted them actively supporting patients and staff throughout our inspection. Staff explained the MDT was critical in terms of supporting patient discharge and reducing time spent in the ED.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. The ED had strong links and relationships with the psychiatric health liaison team, who provided support to ED. The teams told us they had good working relationships and communicated together regularly to plan patient care and treatment. Staff welcomed the new roles of mental health matron and deputy matrons and felt they would add additional support to staff and patients.

**Seven-day services**

**Key services were available seven days a week to support timely patient care.**

The ED, ChED and the clinical decisions unit (CDU) were open 24 hours a day, seven days a week. Patients arrived by ambulance, on foot or as a referral from their general practitioner. The ED had 24-hour access to pathology, and diagnostic tests such as, blood tests, x-rays, computed tomography (CT) scans and magnetic resonance imaging (MRI) scans.

The chaplaincy service was available 24 hours a day seven day a week.

**Health promotion**

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

The service had relevant information promoting healthy lifestyles and support on the wards/units. All the ED areas held leaflets that offered patients advice and guidance on issues such as diabetes, promoting healthy lifestyles and dealing with minor injuries.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff could access additional health care advice for patients, for example the alcohol liaison team. Patients would be signposted to other specialities, for example the diabetes team, smoking cessation or dieticians for specific guidance on healthier lifestyles.

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

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

**Mental Capacity Act and Deprivation of Liberty Safeguards training completion**

Nursing and clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

**Trust level**

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DoLS training courses from August 2018 to July 2019 at trust level for qualified nursing staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental capacity act level 2</td>
<td>135</td>
</tr>
<tr>
<td>Deprivation of liberty safeguards</td>
<td>135</td>
</tr>
</tbody>
</table>

In urgent and emergency care the target was met for all MCA/DoLS training modules for which qualified nursing staff were eligible.

A breakdown of compliance for MCA/DoLS training courses from August 2018 to July 2019 at trust level for medical staff in urgent and emergency care is shown below:

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**Norfolk and Norwich University Hospital**

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training.

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</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Training tab)

In urgent and emergency care the target was met for all MCA/DOLS training modules for which medical staff were eligible.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. All staff we spoke with understood their roles and responsibilities. This was an improvement from our last inspection. The trust had an up-to-date and version controlled policy for MCA and DoLS and staff knew to access this on the trust’s intranet. Staff used credit card sized MCA and DoLS information cards. We noted staff had these within their ID tags and staff told us these had been helpful as a quick reference guide.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff understood their roles and responsibilities under the Children’s Act (2004), the Mental Health Act (MHA) (1983) and knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. Throughout our inspection we noted staff seeking consent to patients prior to any treatment.

When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions. During our inspection we routinely observed staff seeking patient consent prior to treatment. Staff told us they could contact the trust’s dementia specialist nurse and learning disability nurse for any patients who may require additional support or for guidance in relation to the MCA and DoLS.

Staff clearly recorded consent in the patients’ records. Staff made sure they gained patient consent to treatment based on all the information available and clearly recorded consent in the patient records.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Staff we spoke with in the children’s ED had a comprehensive understanding of the importance of the law relating to Fraser guidelines and Gillick competencies when caring for a patient under the age of 16. The Fraser guidelines refer specifically to consent for sexual health services and are an additional guideline to the Gillick competency framework that relates to consent for any healthcare intervention. There were no examples to review during our inspection.
Is the service caring?

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed examples of staff responding with kindness when patients needed help and support, even during exceptionally busy periods. Staff offered reassurance to patients who were in pain or frightened and we observed staff promoting patients.

Patients said staff treated them well and with kindness. Staff recognised patients’ individual needs and we noted in the children’s emergency department (ED) that children were treated with kindness and patience. We spoke with a 12-year-old child who told us that staff had been kind and they felt safe in the department. Their parent told us that they were seen quickly, were satisfied with the care provided and would happily come back to the hospital for any further treatment.

We spoke with two patients who told us they had no ideas on what could be done better within the emergency department (ED), because the staff were working so hard and doing all they could. Another patient told us they had ‘good care’, that staff had offered them food and drink and checked on them regularly.

Friends and Family Test performance

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment.

Response rates for Norfolk and Norwich University Hospitals NHS Foundation Trust from October 2017 to September 2019 are shown below. The trusts response rate varied between 1.0% and 3.7% from October 2017 to September 2019.

Norfolk and Norwich University Hospital NHS Foundation Trusts – response rate October 2017 to September 2019
The chart below shows the mean friends and family test scores, with upper and lower control limits. The width of the control limits are based on the response rates, therefore the higher the response rates (shown by narrower control limits) the more confidence we have in the data.

The trusts recommendation rate ranged from 60.4% in August 2019 to 98.7% in January 2018.

**A&E Friends and Family Test performance - Norfolk and Norwich University Hospitals NHS Foundation Trust**

![Chart showing A&E Friends and Family Test performance](image)

(Source: Friends and Family Test – NHS England)

Staff followed policy to keep patient care and treatment confidential. Staff took appropriate action to manage patient confidentially including locking computer screens, using signage to cover up patient details and having private conversations in appropriate areas.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff we spoke with during our inspection understood the needs of patients with mental health needs. During handovers we observed staff actively seeking to promote the welfare of these patients and ensure their treatment was least restrictive and referred to the appropriate teams as quickly as possible.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. All patients we spoke with told us staff were very helpful and caring and they were treated respectfully. Staff we spoke with knew they had to make reasonable adjustments for some patients who required additional support. During our inspection we noted two patients with learning disabilities being supported by staff. Staff showed non-judgemental attitudes towards the patients, one of whom demonstrated confused behaviour and required additional care to ensure both their and the staffs’ safety.

At the time of our inspection staff were supporting a husband and wife who attended the department, both were patients and one was the carer for the other. The ED staff team worked closely to ensure the couple were not split up, remained close to each other in the ED and involve the patients in their care and decision making. Staff were exploring how to admit one of
the patients whilst providing care to the other without impacting on their personal relationship and
social situation. Staff showed great empathy and understanding of the situation and were seeking
advice from the multidisciplinary team to meet the patients’ needs.

**Emotional support**

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

Staff gave patients and those close to them help, emotional support and advice when they needed
it. Staff we spoke with understood the emotional impact on patients attending the emergency
department. Many patients were experiencing life-changing events, for example road traffic
collisions, falls, and other significant injuries.

Staff supported patients who became distressed in an open environment and helped them
maintain their privacy and dignity. We observed staff supporting a patient who was confused and
had a learning disability. The patient was clearly very distressed, physically lashing out and
shouting. Staff remained calm and professional, reassuring other patients and ensuring the
patient received appropriate support and treatment.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult
conversations. Staff had access to the bereavement team for additional support when breaking
bad news to patients and their families. We observed a medical staff handover where staff
discussed a number of patients who were very ill. Staff prioritised the patients’ needs and
discussed end of life plans in a very sensitive and empathetic manner.

Staff understood the emotional and social impact that a person’s care, treatment or condition had
on their wellbeing and on those close to them. Staff approached patients with open minds, a
willingness to listen despite how busy they were and gave additional support to patients who
were distressed. Staff could request increased staffing for patients who required additional
support and managers were responsive to these requests, even during busy periods. Managers
sought staff from other areas who may be available to sit and provide reassurance to a patient.

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

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

Staff made sure patients and those close to them understood their care and treatment.
Throughout our inspection we observed staff providing information to patients and where
appropriate to other family members.

Staff talked with patients, families and carers in a way they could understand, using
communication aids where necessary. We observed a patient who had recently attended the
department who returned with additional symptoms who was supported by their care team. Staff
worked alongside the patients care team to provide reassurance to the patient and actively
courage them to ask questions in order to understand what was happening. Another patient’s
family was concerned for their loved one’s care. Staff listened and gave additional time to provide
feedback on the patient’s condition to reassure family members. Staff explained they would
access the learning disability nurse for additional support, including pictorial aids. Staff said that
patients often came into the department with a ‘This is me’ document or care passport which
often had a communication guide to assist staff.

Patients and their families could give feedback on the service and their treatment and staff
supported them to do this. The trust had an active patient advice and liaison team (PALS) and
also encouraged patients to leave back following their treatment on comments cards or vial social media. Patient feedback, both positive and negative was shared with the ED staff team. We noted a selection of patient feedback on notice boards across the ED. Staff used a green folder to share and store up-to-date details in relation to the ED. Feedback was shared in the folder, including celebrations of positive feedback and actions taken in response to negative feedback.

Staff supported patients to make advanced decisions about their care. Patients entering the department may have a do not attempt cardiopulmonary resuscitation (DNACPR) or advance decision regarding their care and treatment. Staff checked for this detail during the initial assessment to ensure they respected the individuals wishes.

Staff supported patients to make informed decisions about their care. We observed staff gave patients detailed information regarding their care and treatment. Where appropriate, staff discussed alternative care pathways in order for them to make a decision on their care. We spoke to one patient who had been initially unsure on their care and treatment. The staff gave them clear guidance on going to see their general practitioner (GP) and specific questions to ask regarding their condition.

Patients gave positive feedback about the service. Staff could give examples of how they used patient feedback to improve the quality of care they provided. Staff used notice boards across the department to share “You said – we did” feedback to patients. One example was additional notice boards being used to display waiting times around the department, based on patients saying that they were unsure on waiting times within the ED.

Emergency Department Survey 2018 – Type 1 A&E departments

The feedback from the Emergency Department survey test was positive.

The trust scored about the same as other trusts for all of the 26 Emergency Department Survey questions relevant to the caring domain.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you informed how long you would have to wait to be examined?</td>
<td>3.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. While you were waiting, were you able to get help from a member of staff to ask a question?</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. Did you have enough time to discuss your condition with the doctor or nurse?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. While you were in A&amp;E, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. Did the doctors and nurses listen to what you had to say?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. If a family member, friend or carer wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>8.0</td>
<td>About the same as other trusts</td>
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<tr>
<td>Question</td>
<td>Trust score</td>
<td>RAG</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Q21. While you were in A&amp;E, how much information about your condition or treatment was given to you?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. Sometimes, a member of staff will say one thing, and another will say something quite different. Did this happen to you?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q25. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Before you left A&amp;E, did you get the results of your tests?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q29. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q30. If you did not get the results of the tests when you were in A&amp;E, did a member of staff explain how you would receive them?</td>
<td>5.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>5.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>5.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving A&amp;E?</td>
<td>5.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what symptoms to watch for regarding your illness or treatment after you went home?</td>
<td>6.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left A&amp;E?</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Did staff give you enough information to help you care for your condition at home?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q46. Overall</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
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</tbody>
</table>

(Source: Emergency Department Survey 2018)
Is the service responsive?

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the changing needs of the local population. Information about the needs of the local population was used to inform service planning and delivery. The trust was involved with local commissioners and other health care providers working together to provide urgent and emergency care to patients.

Facilities and premises were appropriate for the services being delivered. The trust recognised that the design of the emergency department (ED) no longer addressed the significant increase in patient demand and there was a need for increased space. The trust was increasing bed space in additional areas to reduce the number of patients held in the ED due to the lack of bed spaces. Staff had produced a business case within the ED to make adjustments to its current assessment and triage spaces, which was due for board review early in the New Year.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. The ED had strong links and relationships with the psychiatric health liaison team, who provided support to ED. The teams told us they had good working relationships and communicated together regularly to plan patient care and treatment. Staff welcomed the new roles of mental health matron and deputy matrons and felt they would add additional support to staff and patients.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff had access to the trusts dementia specialist nurse and learning disability nurse for any patients who may require additional support or for guidance.

Meeting people’s individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff provided care and treatment appropriate to patient needs. Staff told us they could contact the trusts dementia specialist nurse and learning disability nurse for any patients who may require additional support or for guidance. These specialist nurses visited the department regularly and patients with additional needs were flagged on the trusts systems.

Staff supported patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports. Patients entering the ED often had care passports or ‘This is me’ documents to help staff tailor care to a patient’s individual needs. Staff we spoke with knew the importance of these documents in providing continuity of care. One of the patients we observed had a learning disability and entered the ED without ‘This is me’ documentation. Staff explained they had contacted the care home to gather additional details and were waiting for the learning disability nurse to come to the department and provide additional support to the patient.

The service had information leaflets available in languages spoken by the patients and local community. The ED offered a wide range of information booklets throughout all its departments,
designed to support patients to self-manage conditions and minor injuries, for example ankle injury, sprain and strain. All of the leaflets were in English, however staff told us they could request them in alternative formats if required.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. Staff had access to external translation services for patients whose first language was not English.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff gave patients food and drink when it was safe to do so. Staff would ask patients if they had any specific dietary requirements, spiritual or cultural needs prior to providing this service.

Staff had access to communication aids to help patients become partners in their care and treatment. Staff explained they would access the learning disability nurse for additional support, and staff we spoke with within the department told us they had access to pictorial guides. Staff said most patients who came into the department with a ‘This is me’ document or care passport which often had a communication guide to assist staff.

Emergency Department Survey 2018 – Type 1 A&E departments

The trust scored about the same as other trusts for all of the three Emergency Department Survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to A&amp;E last?</td>
<td>6.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 2018)

Access and flow

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

At the time of our inspection the department was experiencing heavy patient demand and was on its highest level of internal escalation, which the trust called OPEL 4. Staff told us that the department was consistently under increased patient demand, often seeing upwards of 400 patients on a daily basis.

Median time from arrival to treatment (all patients)

Managers monitored waiting times however, patients could not access emergency services when needed or receive treatment within agreed timeframes and national targets.

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour.

The trust did not meet the standard over the 12-month period from September 2018 to August 2019. Patients at the trust waited an average of 105.6 minutes from arrival to treatment over this 12-month time period, compared to the England average of 62.7.
Median time from arrival to treatment from September 2018 to August 2019, 2019 at Norfolk and Norwich University Hospitals NHS Foundation Trust

(Source: NHS Digital - A&E quality indicators)

The trust employed emergency department floor coordinators (EDFC) within its main adult ED. These were experienced nurse managers who coordinated staff and services throughout the adult ED and encouraged patient flow. We attended a number of site meetings where staff from across the trust met to discuss resource allocation and patient flow. The trust was experiencing unprecedented patient demand and it was clear that all areas of the trust were in escalation to try and meet patient needs. The trust used its escalation processes to increase bed capacity, but even at ‘Opal 4’ the highest level of escalation there was still insufficient bed space to meet demands which directly impacted on the number of patients waiting in the ED. The trust was at 100% capacity throughout the inspection and a lack of available bed space contributed to waiting times in the ED.

Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From October 2018 to September 2019 the trust failed to meet the standard and performed consistently lower than the England average.

During the winter months, from October 2018 to February 2019, the percentages of patients admitted, transferred or discharged within four hours declined. The lowest percentage over the 12-month time period at the trust was in April 2019 (65%).

Over the 12-month period trust performance varied from 5% lower than the England average in October 2018 to 23% lower in April 2019.

Four-hour target performance - Norfolk and Norwich University Hospitals NHS Foundation Trust

(Source: NHS Digital - A&E quality indicators)
Managers and staff worked to make sure patients did not stay longer than they needed to. However, performance against the four-hour standard varied greatly during our inspection and we noted this dropped to 22% on occasion due to heavy patient demand. Staff we spoke with explained that flow throughout the trust was an issue. At our inspection January 2019, we found that getting specialities to assess patients within the ED was sometimes difficult and not within their respective professional standard of seeing a patient within 30 minutes. This remained an ongoing issue at the time of our inspection. However, clinical staff working in the acute medical unit were praised by staff for their support and commitment to helping flow throughout the department.

The ED worked closely with a local NHS to develop a standard operating procedure for the safe cohorting of ambulance patients at times of increased demand, to enabled ambulance staff to be released back to the community as quickly as possible.

**Percentage of patients waiting more than four hours from the decision to admit until being admitted**

From October 2018 to September 2019 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was consistently higher than the England average and target. The period from January to April 2019 showed particularly poor performance.

At times of increased patient demand, the main ED used escalation processes to meet patient needs. We noted that patients arriving by ambulance were met by triage staff and recorded onto the hospitals arrival system within five minutes in line with Royal College of Emergency Medicine (RCEM) guidance. However, patients then experienced extended waiting periods to be seen by a clinician. The lack of clinical decision makers and the management of the flow through the whole trust affected the ability to stream patients effectively to receive appropriate care and treatment. At the time of our inspection many patients were waiting between four to six hours to be seen and decision made on their care pathway which led to longer stays in the emergency department.

**Percentage of patients waiting more than four hours from the decision to admit until being admitted - Norfolk and Norwich University Hospitals NHS Foundation Trust**
Number of patients waiting more than 12 hours from the decision to admit until being admitted

Over the 12 months from October 2018 to September 2019, 47 patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in June 2019 (12), March 2019 (eight) and August 2019 (six). During our inspection we noted that staff monitored patient waiting times and that no patients waited longer than 12 hours within the ED. Decisions to admit were affected by the lack of medical staff available within the ED and other specialists not consistently meeting internal professional standards.

(Source: NHS England - A&E Waiting times)

Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment

The number of patients leaving the service before being seen for treatments was low.

From September 2018 to August 2019 the trust reported that no patients left the department before being seen.

(Source: NHS Digital - A&E quality indicators)

Median total time in A&E per patient (all patients)

From October 2018 to September 2019 the trust’s monthly median total time in A&E for all patients was higher than the England average.

Performance against this metric was not stable, with patients at the trust spending on average 35.8 minutes longer in A&E than the England average. From December 2018 to April 2019 the total time spend in A&E increased to an average of 47.8 minutes longer than the England average.

Median total time in A&E per patient - Norfolk and Norwich University Hospitals NHS Foundation Trust
Managers and staff worked to make sure that they started discharge planning as early as possible. Staff had a strong focus on hospital admission avoidance and wherever possible referred patients to community based services, or back to their own home with general practitioner (GP) advice. Discharge processes, particularly on the older persons emergency department, focused on using the multidisciplinary (MDT) staff team to safely coordinate early discharge.

Staff planned patients’ discharge carefully, particularly for those with complex mental health and social care needs. Discharges were coordinated by an MDT, with a focus on patient safety and ensuring they had access to the right community based services when they got home. We spoke with members from the MDT who explained the importance of the early intervention team, working with staff and patients to ensure care packages, transport and equipment was in place to avoid reattendance.

Staff supported patients when they were referred or transferred between services. Staff used the electronic patient record systems to share information with other staff across the trust and with community based teams. This encouraged effective discharge as the patients had the required plans in pace to maintain their well being on returning home.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Advice on how to make a complaint to the service was available throughout the department, with posters on notice boards and leaflets. Patients we spoke to were aware the department was experiencing exceptional demands on its services and understood the waiting times to be seen. One patient said, “I know I have been waiting a long time, but I don’t want to complain, they are busy and it’s not their fault”.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with knew that the trust had a complaints policy and how to support patients wishing to make a complaint. Staff explained they would try to resolve the complaint locally but escalate the complaint to a manager to ensure it was recorded and dealt with in line with the trusts policy.

Managers investigated complaints and identified themes. Managers responded positively to complaints and recognised their importance in improving the service. Data supplied by the trust demonstrated that all complaints were investigated and closed at the time of providing data to us.
Summary of complaints

Trust level

From August 2018 to July 2019 the trust received 133 complaints (12.3% of total complaints received by the trust) in relation to urgent and emergency care at the trust. The trust took an average of 34.2 working days to investigate and close complaints. The trust’s complaints policy states that complaints should be investigated and closed as agreed with the complainant. All complaints had been closed at the time of reporting.

A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment – A&amp;E</td>
<td>68</td>
<td>51.1%</td>
</tr>
<tr>
<td>Communications</td>
<td>28</td>
<td>21.1%</td>
</tr>
<tr>
<td>Admission, discharge and transfers</td>
<td>11</td>
<td>8.3%</td>
</tr>
<tr>
<td>Patient care including nutrition/hydration</td>
<td>6</td>
<td>4.5%</td>
</tr>
<tr>
<td>Privacy, dignity and wellbeing</td>
<td>5</td>
<td>3.8%</td>
</tr>
<tr>
<td>Values and behaviours (staff)</td>
<td>3</td>
<td>2.3%</td>
</tr>
<tr>
<td>Prescribing errors</td>
<td>3</td>
<td>2.3%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>2</td>
<td>1.5%</td>
</tr>
<tr>
<td>Clinical treatment - surgical</td>
<td>2</td>
<td>1.5%</td>
</tr>
<tr>
<td>Facilities</td>
<td>1</td>
<td>0.8%</td>
</tr>
<tr>
<td>Clinical treatment - radiology</td>
<td>1</td>
<td>0.8%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0.8%</td>
</tr>
<tr>
<td>Clinical treatment - general medical</td>
<td>1</td>
<td>0.8%</td>
</tr>
<tr>
<td>Transport (ambulances only)</td>
<td>1</td>
<td>0.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>133</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Norfolk and Norwich University Hospital

From August 2018 to July 2019 there were 128 complaints about urgent and emergency care at Norfolk and Norwich University Hospital. The trust took an average of 34.1 days to investigate and close complaints. The trust’s complaints policy states that complaints should be investigated and closed as agreed with the complainant. All complaints had been closed at the time of reporting.

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment – A&amp;E</td>
<td>65</td>
<td>50.8%</td>
</tr>
<tr>
<td>Communications</td>
<td>26</td>
<td>20.3%</td>
</tr>
<tr>
<td>Admission, discharge and transfers</td>
<td>11</td>
<td>8.6%</td>
</tr>
<tr>
<td>Patient care including nutrition/hydration</td>
<td>6</td>
<td>4.7%</td>
</tr>
<tr>
<td>Privacy, dignity and wellbeing</td>
<td>5</td>
<td>3.9%</td>
</tr>
<tr>
<td>Values and behaviours (staff)</td>
<td>3</td>
<td>2.3%</td>
</tr>
<tr>
<td>Prescribing errors</td>
<td>3</td>
<td>2.3%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>2</td>
<td>1.6%</td>
</tr>
<tr>
<td>Clinical treatment - surgical</td>
<td>2</td>
<td>1.6%</td>
</tr>
<tr>
<td>Facilities</td>
<td>1</td>
<td>0.8%</td>
</tr>
<tr>
<td>Clinical treatment - radiology</td>
<td>1</td>
<td>0.8%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0.8%</td>
</tr>
<tr>
<td>Clinical treatment - general medical</td>
<td>1</td>
<td>0.8%</td>
</tr>
<tr>
<td>Transport (ambulances only)</td>
<td>1</td>
<td>0.8%</td>
</tr>
</tbody>
</table>
Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff we spoke with said that mangers provided feedback from complaints that came into the department and took actions to improve the service based on feedback from patients and families. We reviewed staff meeting records form September and November 2019, and found complaints and compliments were discussed with staff.

Managers shared feedback from complaints with staff and learning was used to improve the service. Managers we spoke with explained how they would share complaints during team meetings, safety huddles, newsletters and via email to ensure staff received feedback.

**Number of compliments made to the trust**

From August 2018 to July 2019 there were 116 compliments about urgent and emergency care at the trust. A breakdown of compliments by site is below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk and Norwich University Hospital</td>
<td>101</td>
<td>87.1%</td>
</tr>
<tr>
<td>Cromer Hospital</td>
<td>15</td>
<td>12.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>116</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Since January 2019, the trust aimed to improve collection and recording of compliments.

Compliments are reported monthly to the Patient Engagement and Experience Group (PEEG) and there is a monthly analysis of themes. Divisions can access their data for use at local level and for sharing and learning from compliments. Trust wide themes are identified to show how important care, kindness and staff attitude are to the positive experience of patients. Dignity is a key positive theme. A selection of compliments is shared, and individual wards and areas display and share compliments amongst teams.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)
Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. Whilst new leadership was positively impacting the department, more time was needed to embed change and improve culture.

Urgent and emergency services were led at a senior level by a chief nurse, medical director and chief operating officer. Operationally the service was led by a nursing director, operations director and associate medical director. Day-to-day oversight of the department was managed by the matron, service director and operations manager. Emergency department (ED) flow coordinators managed the department in a very hands-on way, leading and delegating the staff locally to meet patients needs. The management structure was new to the trust and had developed following our last inspection from what was the ‘Winter Team’. The winter team had been specifically developed to deal with the increase in patient flow and demand at winter time. The trust recognised that winter pressures were no longer isolated to winter months and that the ED was facing increased demand throughout the year. It was recognised that new leadership had made a positive impact on the department but that more time was required to embed the changes for long term improvement in the department.

In response to the increased demand the trust had made changes to its leadership team and reporting lines to include the new governance structure and provide clear leadership and focus on meeting service performance targets and quality improvement. Local leaders were working with the trust’s senior leadership team and engaging with external partners, for example local general practitioner services, walk in centres and out of hours services to develop its response to the increased demand.

The management team were committed and determined to drive forward improvements to the service and tackle issues within the department. Staff told us that managers were available to support staff, easily accessible and set high standards for them to achieve.

Staff said the nursing director came to emergency department daily. All of the nursing staff we spoke with were very positive about the divisional leadership team and felt they were experienced and willing to face the challenges currently being faced around patient demand and service design.

We observed the presence of the nursing director, matron and operations manager throughout the day. Staff confirmed the managers had a detailed knowledge of the pressure on the department and took prompt action to address any concerns.

The nurse director had been recognised for their leadership contributions and was awarded the Edith Cavell Award for Outstanding Leadership. The operations manager was awarded the unsung hero award. These awards were based on staff being nominated by their own teams and peers, showing how much the staff team valued its local leadership.

Vision and strategy

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

The emergency department did not have a local vision or strategy. The managers promoted the trust’s wider vision which was to provide every patient with the care we want for those we love the most. To underpin this the trust had a five-year development strategy, with four core goals. Goal one, to be a provider of high quality health and care services to our local population. Goal two, to be the centre for complex and specialist medicine for Norfolk and the Anglia region. Goal three, to be a centre of excellence for research, education and staff development. Goal four, to be a leader in the redesign and delivery of health and social care services in Norfolk.

The trust had five core values that aimed to support the vision and guide the behaviour of everything they did. The values included, being People-focused, we look after the needs of our patients, carers and colleagues, to provide a safe and caring experience for all. Respect, we act with care, compassion and kindness and value others’ diverse needs. Integrity, we take an honest, open and ethical approach to everything we do. Dedication, we work as one team and support each other to maintain the highest professional standards.

The ED team actively participated in the trust’s quality improvement strategy and the performance assurance framework. The ED leadership team were focused on promoting and maintaining quality locally with oversight of finances, staffing allocation, audit outcomes and using the governance assurance framework to drive through change and improve quality.

The trust had an additional children’s strategy (2019-2024) which focused on “Putting children and young people at the heart of all we do”. The trust had recruited additional registered children’s nurses and appointed a matron to lead the children’s ED in line with the trust’s children’s strategy.

Culture

The culture within the medical staff team was challenging and impacted on relationships, decision making and patient flow.

Nursing staff we spoke with described a culture of team working and support for each other. Communication between the team was positive and there was a genuine respect for experience and knowledge within the teams.

We found very different perspective amongst the medical staff team. Some medical staff described a dysfunctional culture within the medical team. Others said that medical staff were doing their best given the current leadership and challenges of increased patient demand. The managers of the service were trying to drive through change. Medical staff we spoke with told us some of the medical staff had been disruptive and deliberately challenging. This made implementing changes difficult to achieve. Medical staff described working together as sometimes fraught, with decisions being ignored and medical team members not willing to get along for the good of the team or the department. Nursing staff gave examples of challenging medical staff or seeking advice, only to be ignored or have their experience dismissed.

The management team were aware of these challenges and the culture within the medical teams, including the impact this was having on day-to-day operations. The trust had invested in an external leadership consultant to run workshops with the medical staff to try and encourage a positive culture of working together. Some of the medical staff we spoke with said these sessions had been beneficial and given an opportunity to establish what was working well and what wasn’t. However, during our inspection there was an obvious divide in the medical staff group.

The medical staff who were committed to implementing change were increasingly frustrated by the lack of development within the medical team. Nursing staff we spoke with gave examples of exemplary leadership from some of the medical staff, particularly in the acute medical unit and
elderly care teams. Staff said it very much depended on which member of the medical team was on duty, and this impacted on the department culture, patient flow and decision making.

We did see some good cooperative, supportive and appreciative relationships among staff especially the multidisciplinary staff team. For example, nursing staff and medical staff working with ambulance staff, physiotherapists, occupational therapists, and mental health staff in a collaborative manner.

Nursing staff we spoke with knew the trust had a freedom to speak up guardian and felt comfortable raising any concerns to their matrons or senior nursing leadership team.

**Governance**

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

There was an effective governance framework in place. Since our last inspection the emergency department (ED) had significantly increased its governance structure and risk oversight. The ED had a dedicated governance and risk team, who reviewed incidents, risks and risk ratings. The team included a clinical governance lead, governance manager, a governance facilitator, incident investigator and the trust were recruiting to the role of governance administrator. This was an improvement on our last inspection. The trust executive board fed into the divisional board, then the sub divisional board and clinical governance committees and then cascaded information to the team meetings.

There were monthly emergency department clinical governance meetings. Staff were involved in the trust’s shared governance system. Meetings had an agreed clinical governance agenda and minute action log template for department clinical governance meetings and agreed template reporting from these meetings to divisions. We reviewed governance meeting records and noted issues of risk, performance and safety were key parts of the agenda. The trust also held a weekly Friday ‘ED Patient Safety and Quality Pathway Audit Group’ which all staff were invited to. External stakeholders attended this group, including representatives from the local clinical commissioning group. This was an improvement on our last inspection.

We reviewed board minutes from the October 2019 governance meetings and noted the agenda included performance, patient safety, incidents, risk and quality, staffing, health and safety, and serious incidents. We observed actions identified assigned to individuals with a tracked plan to ensure they were completed.

The trust governance structure included the clinical safety and effectiveness committee, none clinical safety committee, the Patient Experience and Engagement Group and workforce and education committee.

**Management of risk, issues and performance**

**Leaders and teams used systems to manage performance effectively.** They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. However, they were not following standard operating procedures in relation to managing patients waiting or treatment. The department continued to perform poorly against national treatment standards.
During our inspection we found that the department was not always using the standard operating procedures which were introduced following our last inspection. This was to ensure patients waiting for treatment were cared for safely. Staff told us that they were not always followed particularly when under pressure. We raised this immediately with senior managers who ensured that the SOPs were again followed. We were concerned that leadership in the department did not always have an overview of risk in the department. The department continued to perform poorly against national treatment standards such as time to treatment and hand over times from ambulances. Senior leaders were attempting to address this performance in innovate ways including the use of OPED and the redesign of the patient pathway. However, the trust remained amongst the worst performing trusts in England for some metrics at the time of our inspection.

The trust had held daily (weekdays) serious incident group meeting chaired by the chief nurse and medical director or agreed deputies held to review all incidents occurring in the previous 24 hours (72 hours post the weekend). These meetings were to identify any immediate safety actions from incidents and share learning through across the trusts wider teams. The trust had a chief executive officer assurance panel set up to review Never Events and the most complex serious incidents.

Representatives from the emergency department teams (ED) attended mortality and morbidity (M&M) meetings to look at deaths that occurred in the ED, including any learning or risks identified, which may have contributed to the death. We reviewed M&M meeting minutes from July, September and November 2019 and found these covered learning from deaths, mortality reviews, mental health death reviews and updates from the trust medical examiner, amongst other key information.

The trust clinical safety and effectiveness sub-board received reports and information from all divisions as well as trust-wide governance committees and triangulated messages and themes. Clinical safety and effectiveness sub-board reported to management board through the integrated performance report, the safety supplementary reports, slides and the minutes of its meetings.

The quality and safety committee received regular reports relating to serious incidents, safety, effectiveness and caring, patient experience and scrutinised and challenged all aspects against a regular schedule of work.

Managers we spoke with during our inspection were aware of the risks on the trust risk register in relation to the emergency department. We noted the top three risks posted on notice boards throughout the ED, and staff we spoke to were clearly aware of the main areas of concern. Staff told us the main risks included ambulance handover delays, lack of ambulatory minors and major cubicle capacity. These risks were on the risk register, and risk rated, with updates on actions taken and who was responsible for oversight of the risks.

### Information management

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

Staff we spoke with during our inspection demonstrated they had a good understanding of performance across the department and gave examples of how performance was used to try and improve performance across the ED. Staff used the trust’s IT system to identify bed capacity across the hospital and had introduced three large monitor screens in the staff handover area.
which displayed key departmental information. For example, current performance against handovers and triage, bed capacity and staffing allocation.

Staff had access to information they needed to carry out their roles effectively with policies and procedures available on the trust’s intranet, using computer work stations on wheels (COWS).

At our last inspection in January 2019 we noted throughout our inspection that the incoming ambulance alert system which used a large IT screen failed routinely, often whilst staff were involved in handovers with ambulance crews. During our recent inspection we noted this issue was still occurring creating ongoing frustration amongst the staff team, who were unable to rely on the system especially at busy periods. We had no incidents related to this issue, or that it affected patient safety. However, staff told us is did happen frequently and made use of the display screen difficult at times.

We reviewed the emergency department staff newsletter which shared information with staff regarding performance, recruitment activities and audit. Computer screen savers around the department showed information around infection control, safeguarding and other key information for staff.

The trust had a data sharing agreement with community-based health improvement practitioners (HIPs) to target working with high intensity patients for example frequent attenders. This was facilitated by the multidisciplinary staff team and involved ED staff and local stakeholders, for example the police, ambulance service trust and social care representatives. This was an improvement on our last inspection.

**Engagement**

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

Staff we spoke with said there had been a definite change in staff engagement within the ED. The new managerial structure and introduction of the childrens ED matron had encouraged dialogue within the nursing teams.

The ED nurse director had an open door session weekly to encourage staff to speak with them and discuss departmental performance, how the team was working together or share any good practice. Staff we spoke with said the opportunity to meet with the nurse director was extremely valuable. This enabled them to get things off their chest and share any concerns as they knew action would be taken to improve things.

The governance team had introduced ‘four for the floor’. These were processes to improve four key areas of practice. Two of these areas included improving engagement with patients. One was to ensure staff used ‘hello my name is’ when introducing themselves to patients. Another was to reintroduce patient handovers at the patient’s bedside, to ensure the patient was fully engaged with their care.

The new chief executive officer was keen to improve staff engagement and had spent time within the ED meeting with the staff team.

Patient feedback was by the friends and family test (FFT), through the Patient Advice and Liaison service (PALS) and through “You said we did” which staffed displayed throughout the ED.

Staff shared feedback from patients in team meetings. We reviewed team meeting records which showed staff openly discussed patient feedback and made changes based on the comments.
The trust continued to work with the local NHS ambulance trust to arrange services to meet the needs of local people and deal with the increased patient demand. Staff we spoke with said this engagement was important in terms of coordinating local health care and influencing patient flow.

**Learning, continuous improvement and innovation**

**All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.**

The ED had introduced monthly ‘Handy Man’ walk arounds with ED matron and trust handy man to identify outstanding minor works and then again, the following week to ensure that the works were completed. This was an improvement from our last inspection.

The trust had been successful in its recruitment processes and vacancies had significantly reduced. The ED matron and nurse director held twice weekly roster ‘look ahead meetings’ to plan staffing rotas and ensure cover was in place to fill any gaps. This was an improvement from our last inspection.

The nursing director had an open house session every Thursday afternoon, where staff could drop in and discuss their training and development needs. Staff we spoke with valued this opportunity and said the nursing director was extremely supportive of additional training and skills development. The ED also had monthly nursing ‘Career Clinic’ drop in session with nurse director, ED matron and trust education team. This was an improvement from our last inspection.

The trust had seconded a nurse for 12 months as infection, prevent and control (IPC) lead within the ED. We noted the IPC lead within the ED, offering guidance to staff and carrying out IPC audits.

The practice development nurse supported the learning and development needs of staff and actively worked alongside managers to provide training and development opportunities. All newly qualified nurses completed an eight-week induction programme which included the trust welcome pack and detailed information to orientate them into the department.

The trust had a data sharing agreement with community based health improvement practitioners (HIPs) to target working with high intensity patients for example frequent attenders. This was facilitated by the multidisciplinary staff team and involved ED staff and local stakeholders, for example the police, ambulance service trust and social care representatives. This was an improvement on our last inspection.

The triage process for patients with mental health needs had changed. Patients were previously risk assessed as low, medium and high risk. The staff used ‘Screening’ rather than risk assessing. The use of the term ‘screening’ is deemed more appropriate than risk assessment within mental health services. This is because staff screen the persons mental health to identify risks and needs. The screening process enabled staff to screen patients as routine, enhanced or immediate risk. This enabled patients in crisis to feel safe by using appropriate language. For example, staff using ‘immediate risk’, rather than ‘high risk’. This was an improvement from our last inspection.

The children’s emergency department (ChED) had introduced a risk screen for children with
learning disabilities or Autism and created staff link roles to improve knowledge in relation to risks associated with this patient group. The ChED staff team had also introduced daily safety huddles three times per shift to share information on patients who may be at increased risk and require additional support or specialist intervention. This was an improvement from our last inspection.

The trust met the Royal College of Paediatrics and Child Health (RCPCH) standard of having two registered children’s nurses on every shift. The trust had also recruited a children’s matron as part of its ED management team. This role was highly valued by the staff team who said it had brought continuity and leadership to the department. This was an improvement from our last inspection.

The ChED had a dedicated play team covering 12 hours shifts six days a week. This was an improvement from our last inspection.

The trust had a data sharing agreement with community-based health improvement practitioners (HIPs) to target working with high intensity patients for example frequent attenders. This was facilitated by the multidisciplinary staff team and involved ED staff and local stakeholders, for example the police, ambulance service trust and social care representatives. This was an improvement on our last inspection.

The ED had a dedicated governance and risk team, who reviewed incidents, risks and risk ratings. The team included a clinical governance lead, governance manager, a governance facilitator, incident investigator and the trust were recruiting to the role of governance administrator. This was an improvement on our last inspection.
Surgery

Facts and data about this service

The trust offers a range of general and tertiary surgical services covering general surgery, urology, trauma and orthopaedics, ear nose and throat (ENT), ophthalmology, oral surgery, plastic surgery, thoracic surgery, vascular surgery, and pain management. Many specialties run a hub and spoke service, with complex surgery performed at Norfolk and Norwich University Hospital (NNUH).

The trust has 29 main operating theatres across two sites covering:
- general surgery
- urology
- trauma and orthopaedics
- ear, nose and throat (ENT)
- ophthalmology
- oral
- plastic
- thoracic
- vascular surgery

There are seven surgical wards with 230 inpatient beds for elective and non-elective patients. A further 20 beds for non-elective patients are located in the surgical emergency assessment unit (EAUS) based on Easton ward. This service receives GP referrals via a telephone service as well as referrals from A&E.

The department has access to 29 theatres (six in the day procedure unit - DPU), 17 in the main theatre complex, two obstetric theatres, two ophthalmic theatres, one Vanguard theatre and one at Cromer Hospital). Elective surgery is provided from Monday to Saturday. There are three emergency theatres which run every day, two of which provide 24 hour a day care, with the additional one covering from 7.30am to 2am daily.

All elective patients are assessed pre-operatively by nurses in the pre-assessment unit and, where appropriate, by a consultant anaesthetist. Patients are seen again on the same day admissions unit for final pre-operative checks. The orthopaedic department specialises in major joint revision surgery, pelvic reconstruction surgery spinal surgery and paediatric surgery.

The trust has a supra-regional cancer status for penile cancer and is the regional cancer centre for head and neck cancer. The trust also has a regional diagnostic centre for sarcoma as well as acting as the regional centre for vascular surgery. The trust is among the largest national centres for robotic prostatectomy and for colorectal resection.

The trust is a participant in getting it right first time (GIRFT); with initiatives in orthopaedics to reduce costs and in urology to reduce rates of intervention for urinary tract stones by 50%. The ENT and urology teams are driving the Strategic Transformation Partnership (STP) agenda to redesign and enhance services regionally in partnership with neighbouring trusts.

Our inspection of Norfolk and Norwich Hospital was unannounced. Prior to our inspection we reviewed data we held about the service along with information we requested from the trust.

During the inspection we spoke with 32 members of staff including doctors, nurses, therapists, health care assistants and non-clinical staff. We spoke with ten patients and two relatives, reviewed 12 patient records and considered other pieces of information and evidence to come to our judgement and ratings.
The trust had 48,882 surgical admissions from March 2018 to February 2019. Emergency admissions accounted for 17,491 (35.8%), 23,455 (48.0%) were day case, and the remaining 7,936 (16.2%) were elective.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

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

Mandatory training completion rates

Nursing and medical staff received mandatory training but did not always keep this up to date. On our last inspection we found staff training rates were below trust compliance targets. During this inspection data provided by the trust showed compliance levels still fell below the required target for just over half of the nursing and medical staff training modules. However, module completion rates were much closer to the trust target.

The trust set a target of 90% for completion of mandatory training (MT). Staff accessed training through online learning and face-to-face training sessions. Staff told us their MT was all up to date or had been booked. Staff said they had access to mentor days if needed.

Gateley ward nursing staff had completed competencies for blood transfusion, IV admin, cannulation and taking blood. They would receive an alert on the system when they were due for completion.

Trust level

A breakdown of compliance for MT courses from August 2018 to July 2019 at trust level for qualified nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>475</td>
</tr>
<tr>
<td>Fire safety</td>
<td>475</td>
</tr>
<tr>
<td>Clinical record keeping</td>
<td>433</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>468</td>
</tr>
<tr>
<td>Information governance</td>
<td>464</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>427</td>
</tr>
<tr>
<td>Infection prevention (level 2)</td>
<td>421</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>399</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>285</td>
</tr>
</tbody>
</table>
In surgery the 90% target was met for six of the 12 MT modules for which qualified nursing staff were eligible, while the completion rate for three further modules (infection prevention level 2, venous thromboembolism and blood transfusion) were just below the target.

A staff nurse told us they delivered bespoke IPC (level 2) training with a training lead so clinical staff would be complaint. Trust wide the training team was smaller, so more modules were given centrally. Resuscitation and manual handling modules were the trainer team’s priorities in meeting compliance. These trainers were clinical staff so also had to work shifts during our inspection. We heard the training team had lost one bank staff and had another on long term sickness which only left one manual handling trainer. The service were working to train the trainer to grow their team by a few extra trainers before April who were managed in-house.

A training team member told us there were two venous thromboembolism (VTE) modules staff needed to complete. One was theory-based online and the other was given by a compression stockings trainer. Compression stockings are useful for treating conditions associated with the management of venous disease affecting the legs. They told us staff on fixed roster patterns were harder to accommodate which affected VTE training completion rates.

At the time of our inspection three fire train the trainers were compiling a multi-faceted training programme. This included table top evacuation scenarios to build the trainer's confidence.

A day procedure unit (DPU) staff member told us maintaining competency of the blood transfusion training module was hard as this was rarely needed in theatres. However, day surgery ward staff were comfortable with IV and catheter training.

The trust told us some of their anaesthetics medical staff had merged workloads with the critical care team. Therefore, the analysis below includes some medical staff working across surgery and critical care.

A breakdown of compliance for MT courses from August 2018 to July 2019, at trust level for medical staff in surgery (and critical care) is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>326</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>312</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>284</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>338</td>
</tr>
<tr>
<td>Clinical record keeping</td>
<td>321</td>
</tr>
<tr>
<td>Fire safety</td>
<td>322</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>311</td>
</tr>
<tr>
<td>Information governance</td>
<td>301</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>286</td>
</tr>
<tr>
<td>Basic life support</td>
<td>272</td>
</tr>
<tr>
<td>Infection prevention (level 3)</td>
<td>277</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>60</td>
</tr>
</tbody>
</table>
In surgery (and critical care) the 90% target was met for five of the 12 MT modules for which medical staff were eligible. The lowest module completion rates where medical staff did not meet MT trust targets were resuscitation, infection prevention (level 3) and basic life support which were all 80% or less. Less eligible medical staff still had to complete resuscitation training overall.

The mandatory training was comprehensive and met the needs of patients and staff. The MT programme included the necessary subject range to enable staff to provide safe quality care to patients. Staff we spoke with told us the MT programme met their needs.

However, less than half of all staff’s MT compliance was above 90% on the Edgefield ward in October 2019. A staff nurse on Docking ward had not completed their infection prevention control training as the course was full. They preferred to book on their day off to avoid any issues with being freed from the ward.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. The trust's mandatory training programme included modules related to dementia and learning disabilities. The mandatory safeguarding training also included mental capacity act (MCA) and deprivation of liberty safeguards (DoLS) training. For example, mental health nurses, clinical educators and the training team could deliver courses in the DPU areas according to need.

Managers monitored mandatory training and alerted staff when they needed to update their training. Ward managers told us they reviewed MT completion dates when completing the off duty schedule. Managers booked face to face training for staff or alerted staff if they needed to complete E-learning modules. A DPU staff nurse told us they could access half day sessions to complete online MT. The trust library also ran drop in clinics and there were monthly trustwide training days in the lecture theatre.

Staff were contractually obliged to complete MT and were given time to achieve this. We heard clinical workers could not access computers easily enough to complete their MT. A clinical educator told us the trust often carried out IT system updates on Saturdays when staff had more time to complete or refresh their MT modules.

Safeguarding

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

Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training.

The tables below include prevent training as a safeguarding course. Prevent works to stop individuals from getting involved in or supporting terrorism or extremist activity.

Trust level

Nursing staff received training specific for their role on how to recognise and report abuse. Nursing staff told us they had completed safeguarding level two training. They would report any safeguarding concerns to the nurse in charge and were aware of how to contact the safeguarding team.
Safeguarding training included recognition, recording and reporting of female genital mutilation (FGM) for all staff, and further bespoke training was offered to departments who might identify FGM on a more regular basis, such as the gynaecology service. Staff we spoke with were knowledgeable about FGM and sexual exploitation, staff from the day care ward we spoke with, had completed the additional training regarding FGM. The trust had weekly grand round clinical case meetings which were attended by the safeguarding named nurses and named doctors and the safeguarding leads. This provided a forum for additional case discussions and peer review of raised safeguarding concerns as required.

A breakdown of compliance for safeguarding training courses from August 2018 to July 2019 at trust level for qualified nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
<th></th>
<th></th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>389</td>
<td>396</td>
<td>98.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent - level 3</td>
<td>437</td>
<td>456</td>
<td>95.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>441</td>
<td>472</td>
<td>93.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>63</td>
<td>75</td>
<td>84.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery the 90% target was met for four of the five safeguarding training modules for which qualified nursing staff were eligible. Overall trustwide safeguarding completion rates for nursing staff were 94.28% which was above the trust target. 12 eligible nursing staff had not completed the training module safeguarding children (level 3).

Medical staff did not always receive training specific for their role on how to recognise and report abuse. Most eligible medical staff had completed safeguarding adults to level two as well as children to level two and three. However, completion rates were not in line with the trust’s target of 90%. The safeguarding children level three training completion rate had the lowest completion rate, but this should be considered in context with the low numbers of eligible medical staff.

The divisional leadership team had measures in place to address the completion of safeguarding training. They had identified medical staff found MT attendance difficult due to demands and pressures on their time. As a result, divisional and training leads scheduled face-to-face training as part of junior doctor supervision and learning sessions.

The trust informed us some of their anaesthetics medical staff have merged workloads with the critical care team. Therefore, the analysis below includes some medical staff working across surgery and critical care.

A breakdown of compliance for safeguarding training courses from August 2018 to July 2019 at trust level for medical staff in surgery (and critical care) is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
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<th>Trust target</th>
<th>Met (Yes/No)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevent - level 3</td>
<td>279</td>
<td>336</td>
<td>83.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>273</td>
<td>337</td>
<td>81.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>270</td>
<td>355</td>
<td>76.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>13</td>
<td>18</td>
<td>72.2%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery (and critical care) the 90% target was not met for any safeguarding training modules.
for which medical staff were eligible. We saw that the division planned to meet compliance for this training by March 2020.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff we spoke with knew the protected characteristics under the Equality Act and could explain actions they would take to protect patients from harassment and discrimination. Staff from the day care unit gave us examples of how they made adjustments for patients with complex needs, such as patients listening to music during their transfer to theatre to reduce anxiety.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to identify patients at risk of emotional and physical harm. Staff gave examples of the types of situations where they would raise concerns. For example, where a patient would have unexplained bruises or injuries to their body or if they felt vulnerable patients were at risk of psychological or financial abuse.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Day procedure unit (DPU) staff told us they were concerned about the lack of swipe access and security throughout the six theatres which were close to the children’s bay. The children’s bay had swipe access only which was used when children were in the area. When adults were cared for in the area the swipe access was not used which enabled people to move around the department freely. Staff felt this was a DoLS risk as reception was only staffed between 7am and 10pm and therefore patients could not leave the department without asking a staff member. The DPU also had only two registered nurses and one health care assistant who could not observe all the patients and visitors at once.

Staff could access safeguarding policy documents on the trust’s intranet. We reviewed both the safeguarding adults and children’s policies. These set out the roles and responsibilities of staff and the types of abuse. The policy documents were within the review date and referenced legislation and national guidance.

Staff followed safe procedures for children visiting the ward. All child patients in theatre and recovery had two practitioners until they were fully awake. They would then be escorted to bays on the Jenny Lind and Buxton wards. We checked the paediatric resuscitation trolley and all equipment was in date, cleaned and checked daily using a list.

**Cleanliness, infection control and hygiene**

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

All ward areas were clean and had suitable furnishings which were clean and well-maintained. Theatres and wards were all cleaned regularly by a private contractor. We saw cleaning schedules were completed daily. We saw disposable curtains in used within ward bays with dates displayed when they were changed. On wards each bay and side room had hand washing facilities for staff, patients and visitors to use. There were hand decontamination gel dispensers at ward entrances in corridors and at hand washing sinks.

The service generally performed well for cleanliness (make reference to PLACE scores where present). Theatres and the DPU’s cleaning checklist had triple audit oversight weekly comprising food, medicines and the rooms. Fridge temperatures were all audited by pharmacy.
Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We saw completed daily and weekly cleaning checklists had been signed and dated on all the wards we visited. Routine cleaning summaries were displayed outside wards on dashboards.

Theatres had put QR codes (a sort of bar code) on resuscitation trolleys in theatres and DPU. These were scanned by the member of staff who was checking the trolley on that day. It allowed managers to see remotely to see if equipment had been checked and escalate it if the checks were not recorded as complete.

The trust followed the national colour coding scheme (red, blue, green and yellow) for all cleaning items such as mops, buckets and cloths.

Staff followed infection control principles including the use of personal protective equipment (PPE). For example, in main operating theatres we saw the anaesthetist wearing a gown when performing an epidural and all staff wearing sterile single-use gloves. Theatres and recovery staff were prompted to use the linen skips provided in the changing rooms to dispose of their used scrubs after their shift.

The service’s theatres and recovery staff followed NICE CG74 guidance around best evidence in respect of pre and postoperative phase uniform and cleanliness. Uniform audits were undertaken across theatres and recovery in June 2019. Results demonstrated the majority of staff complied to the theatre attire policy but there were a few themes for improvement around jewellery, IPC and scrubs being worn outside the building.

Patients told us they had seen staff washing their hands and using hand sanitiser gel before and after treatment or contacting them. However, on the docking ward we saw a nurse removing a drain before touching another patient. This meant there was a risk of cross contamination.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Surgical equipment had yellow stickers to indicate they were cleaned. We saw ‘I am clean’ stickers on all ward equipment we visited. Fire extinguishers and any electrical machinery was in date and had been PAT tested. DPU staff used a toy cleaning checklist on the children’s wards.

Staff worked effectively to prevent, identify and treat surgical site infections. For example, the DPU had undertaken a methicillin-resistant staphylococcus aureus (MRSA) audit. MRSA is a type of bacteria resistant to several widely used antibiotics. This means infections with MRSA can be harder to treat than other bacterial infections. The service had no MRSA bacteraemia’s from August 2018 to July 2019. All escalation patients at pre-assessment were swabbed within 28 days of their admission. The date and result of their last swab was identified on their situation, background, assessment, recommendation (SBAR) form. SBAR is an easy to use communication tool in structured form that enables information to be transferred accurately between individuals.

Staff used records to identify how well the service prevented infections. The service carried out weekly internal IPC audits, with actions undertaken as required. Results from September 2019 showed there were no divisional areas scoring lower than 80% compliance.

At the time of our inspection the trust had distributed viral gastroenteritis information for patients, relatives and carers to try and reduce the hospital’s number of norovirus cases.

The service carried out IPC continuous improvement strategy work in response to issues with high dusting, unsuitable equipment such as split chairs and staff not always being bare below the elbows. The trust’s private cleaning contractor attended the hospital infection committee to share
results and audits. Service leads told us work was underway to extend continuous improvement and audits to non-ward areas and theatres.

Environment and equipment

The design and maintenance of premises kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, the service did not always have suitable facilities or enough equipment.

Patients could reach call bells but staff did not always respond quickly when called. Patients told us staff were occasionally slow to answer call bells and one patient said staff did not always check on them frequently. We read a quality assurance audit for accreditation on the Docking ward in October 2019 where call bells rang for substantial periods of time whilst the audit was taking place.

The design of the environment followed national guidance. For example, all areas of the day procedure unit (DPU) had single sex bays and dedicated patient toilets. The service had ligature free side rooms available as required on the surgical emergency assessment unit (EAUS) and Coltishall wards. The service had 12 consultant rooms in the pre-assessment clinic.

However, the service did not have suitable premises to care for all patients. Building was underway to expand facilities in the interventional radiology unit (IRU) by early April 2020. The DPU was used to care and treat inpatients in an area designed for children. This was due to the lack of capacity in the rest of the hospital. This meant children requiring day procedure had to be admitted to the children’s ward rather than the DPU for their procedure. The paediatric bays in the DPU recovery were not child friendly. For example, we saw no pictures, curtains, tablet devices or equipment suitable for children.

The DPU was not being used for its intended purpose but as an escalation area for patients where no other suitable inpatient ward bed was available. This meant the environment was partly unsuitable as there was no showers or tables. We reviewed the service’s surgical patient step down criteria in the standard operating procedure (SOP) for use of DPU as an escalation area. This stated; ‘patients must not stay longer than the following morning as there are no shower facilities on DPU’. Following our inspection, the trust told us that staff had identified the DPU as the most appropriate place for an escalation area at a meeting with approximately 50 members of staff. There were associated operating procedures and risk assessments in place for the use of the area and risks were recorded on the surgical risk register.

We found the environments in IRU and the DPU were suboptimal for patient care on our last inspection.

Staff carried out daily safety checks of specialist equipment. Ward staff completed daily checks of the emergency resuscitation trolleys. These had all been checked daily with equipment in date. Adult and children’s resuscitation trolleys in DPU and the Vanguard unit had QRS codes attached. We also checked the airways management trolley in DPU. Staff received email alerts if checks were not completed. There were monthly checks of expiry dates and contents. Theatre and recovery staff were prompted to leave all emergency trolleys in a state of readiness at all times. The service’s January 2019 monthly newsletter showed a recent photo of a trolley left in an unacceptable state as a warning.

Specialist equipment was shared between different wards within the service. For example, the Cringleford ward lent their bladder scanner to other wards and kept a log book to monitor where it was.
We saw daily checking of essential clinical equipment in theatres. Emergency equipment was compliant with the management and decontamination of surgical instruments used in acute care guidance as per the health technical memorandum (HTM 01-01 part A).

However, the service had equipment issues in theatres. During a random check of orchestra infusion pumps in main theatres, ten out of ten pumps were found to be dirty. This was first identified in October 2019 when a pump was sent for repair. The broken equipment label had marked the item as cleaned. Service leads reminded staff to clean the pumps daily and ensure this did not happen again. They planned to carry out another random spot check.

Since our inspection, service leads had reviewed the 10 aging defibrillators risk at their divisional risk review meeting in December 2019. They had secured capital funding to replace all defibrillators. They planned to complete the last phase of the two model’s clinical evaluation by April 2020. The order for new defibrillators was placed and awaiting arrival.

The service did not always have suitable facilities to meet the needs of patient’s families. A patient on the Docking ward told us the day room was unsuitable and too small as job applicants awaiting an interview had been sat next to other patients with a cannula/intravenous (IV). Staff were aware of this as a receptionist had come in to apologise. We checked a quality assurance audit for accreditation on the Docking ward in October 2019 where areas for improvement included the need for patient name boards by side rooms and the replacement of cork boards as falling apart and not able to keep clean.

At the time of our inspection senior staff and the patient services lead had identified a lack of linen orders and routine cleaning as in other wards. They were in the process of seeking funds for 14 new drip poles. 12 had already been ordered for inpatients in recovery.

The service did not always have enough suitable equipment to help them to safely care for patients. Service staff could access larger slide sheets, hoists and gowns for bariatric patients. Theatre staff had their own up to date intranet for consumables and procurement where they could chase any item delivery delays, query particular items and link to suppliers websites. Service leads asked staff to share their thoughts on how the intranet page could be improved to become more relevant and useful. They could contact two members of staff to ask questions about stock issues or the website.

However, health care assistants on docking ward told us there were not always enough slide sheets or inflatable boots (to prevent pressure ulcers).

The service’s ophthalmology ward had three old retinal cameras that were causing issues such as perished rubber and lots of artefacts which made grading of images difficult. The cameras were all over 12 years old despite their lifespan being approximately six years. Staff were told in April 2019 the cameras were obsolete as parts cannot be obtained. They were no longer covered by the maintenance contract under which they were serviced annually. This meant lack of working equipment put the service at risk and caused delays for patients. The service had reviewed and mitigated the long-term risk, by replacing any broken cameras with rentals until the purchased equipment arrived. A capital bid for the new retinal cameras was approved in November 2019. At the time of our inspection we were told these were soon to be purchased and after our inspection, service leads told us the risk had been archived at their divisional risk review meeting in February 2020, as new retinal cameras had been delivered.

We saw an equipment risk in theatres on the divisional risk register from January 2019. This related to titus induction heads expiring past their serviceable life with spare parts no longer being easily to find. Funding had been applied for to commence a rolling replacement.

The service was looking to introduce sterile labels into theatres for use in sterile fields. They
requested theatres and recovery staff feedback on which of two proposed solutions to use in October 2019’s monthly newsletter.

The service planned to have separate adult and children surgical outpatients clinics by 2020.

Staff disposed of clinical waste safely. For example, sharps bins were signed and dated at the start and end of use with none exceeding the fill line. We checked the emergency chemical spill kit bag in main theatres were all full and in date. The service had theatre guidelines for the management of checking and counting of swabs, sharps and instruments including medical devices. When theatres and recovery staff did not follow these guidelines, service leads reminded them of trust policy. For example, they identified swabs were being modified for certain procedures so quoted a policy extract in the June 2019 monthly newsletter.

Swabs must not be cut, wilfully damaged or divided into two or more pieces (AfPP 2016). This includes not cutting tapes from swabs as the tapes are not radio opaque. If alteration is made for any reason it should be documented in the patient’s notes, highlighted on the dry wipe board and included in the count. Such incidents should be reported via DATIX as potential patient safety incidents to facilitate investigation to establish why a suitable item was not available. Where necessary a risk assessment should be undertaken.

However, on the Edgefield ward we found gloves on the emergency resuscitation trolley had expired in November 2019. On Docking ward a yellow bin full of clinical waste had no labelled indication of signature or dates. We raised this with staff and it was replaced.

Day procedure unit (DPU) wards had no disposal hold which meant disposal bins were visible near lifts where pre and post-operative patients passed by. We heard overflowing waste occasionally obstructed lifts. The service made unsuccessful attempts to resolve this issue by rerouting patients, curtaining off the area and constructing a dedicated disposal hold. The service included this risk on the DPU’s risk register.

The service had carried out a quality improvement (QI) life project in September 2019 to improve the waste management of potentially recyclable materials within the operating theatre environment. By September 2020 theatres and recovery planned to start a recycling programme which reduced the volume of clinical waste by further recycling and use of other available waste streams.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them appropriately. Staff completed the World Health Organisation (WHO) five steps to safer surgery checklist in theatres including marking of the surgical site. The service had recently reviewed and updated this process to focus on safety.

The WHO surgical checklist was used for radiological interventions and adapted to fit local practice. We found the WHO checklist was embedded in theatres and staff managed this process well. The WHO surgical safety checklist and implementation manual was published in 2008 to increase the safety of patients undergoing surgery. It is designed the ensure the right patient receives the right operation and appropriate care during their perioperative pathway.

The service ensured risk based pre-operative assessments were carried out in line with guidance on pre-operative day cases and inpatient assessments by carrying out audits. The checklist was...
audited monthly and was found to ensure good compliance. Between August and September 2019 we saw improved results in WHO form completion compliance. ORSOS WHO completion also remained above 99%. Audit results and learning were shared across the surgical division. The service’s next steps for all the WHO checklist audits were to improve the debrief and team brief compliance, improve and develop a team approach to the sign-in, improve staff awareness of the results and continue to audit.

However, not all good practice around patient safety was embedded or consistently applied. For example, temperature measurements of adults in surgery was carried out randomly and at the anaesthetist’s discretion. We observed pre-assessments in theatres where the patient’s temperature was only taken initially on the ward and not recorded mid-case, every 30 minutes or in recovery. Staff left these observations blank on the pre-operative checklist. This meant patients were not monitored enough to ensure they had no adverse reactions post-procedure.

Service leads asked theatres and recovery staff to report any issues or concerns surrounding the WHO checklist on the trust’s incident reporting system to see how well the process was working. For example, if patients came to theatre without being marked or having consented. Senior staff would then feedback to the ward. Staff were also asked to report if they were asked to undertake the WHO team brief separately for the anaesthetist and surgeon instead of one team brief together. Service leads reminded staff they were still required to mark a patient’s surgical site before they were brought to theatres if a patient was having a procedure under local anaesthetic.

A lack of practice audit in theatres including skin marking was raised on our last inspection as an area for improvement.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff used the NEWS2 tool and updated patient records in line with their NEWS score’s monitoring frequency. For example, patient records we checked with a NEWS score between one and four were updated at least every six hours. In recovery the consultant physician used NEWS2 scoring which showed best practice guidance. The service did not start scoring patients until they were about to leave recovery using the last set of observations.

NEWS2 scores on most surgical wards were shown on digital dashboards for easier recognition of deteriorating patients. However, scores were not shown on the Edgefield ward patient dashboard. Instead they had a whiteboard but this was not always updated. This meant staff had less clear and quick oversight of patients at risk of deterioration. For example, we saw one patient deteriorate from a NEWS2 score of one to six. We raised this with the nurse in charge who said between ward rounds staff knew which higher scoring patients were more at risk if patients did not alert them using their call bells.

We checked a NEWS2 chart which had escalated from a score of one to six. The patient’s observations had increased to hourly as per the tool’s guidance but the ward’s whiteboard was not adjusted. We informed staff who were not able to confirm observations were recently checked. This meant staff lacked oversight in being able to recognise and respond to the deteriorating patient.

We saw evidence of the ‘Sepsis 6’ care bundle being used for the management of patients with presumed/confirmed sepsis. There was an escalation policy for patients with presumed/confirmed sepsis who required immediate review. Patients with suspected/confirmed sepsis received prompt assessment when escalated to the multi-professional team. They were seen by the critical outreach team for high dependency unit (HDU) or intensive treatment unit (ITU) review. Patients with AKI and sepsis were named and highlighted on the ward safety huddle by the deputy sister. However, huddles only took place daily. This meant there was a risk susceptible patients admitted/transfered onto wards later in the day could be overlooked for timely review.
The service delivered treatment to patients with presumed sepsis within the recommended sepsis pathway timelines. For example, they prescribed antibiotics within the hour and stayed with patients when they took these.

The service successfully trialled and implemented the WHO debrief forms and moving the WHO team brief records onto paper. Theatres and recovery staff used one piece of paper with the team brief on one side and debrief on the other. This replaced diaries and helped staff improve and standardise the team brief and debrief quality across theatres. Theatre teams produced a monthly summary of debriefs to capture actions, whether completed or not. This demonstrated their progress and communicated learning.

At the time of our inspection the service’s peri-operative checklists had recently changed. These were filtering in as old forms were used up. Staff were reminded to read the governance board for more details and had a contact for any queries.

Staff knew about and dealt with any specific risk issues. Service leads prompted theatres and recovery staff to adhere to the WHO checklist for all emergency cases surgeon sign in. The monthly newsletter in June 2019 highlighted a few incidents where patient consent forms were incorrect and not identified until ‘time out’. This meant after the patient was anaesthetised. On one occasion the surgeon had not seen the patient before taking them to theatre.

In response the service decided the operating surgeon should be present to participate in the WHO sign in for all emergency procedures in the anaesthetic room or theatre. They had support from the surgical divisional board and service directors. Service leads emphasised this did not negate the need for a team brief but was an additional step to improve patient safety and care. They asked staff to liaise in advance with the operative team to ensure minimal delays and incident report any non-adherence.

A nurse in charge on the Coltishall ward told us her biggest concern was the very high number of medical or boarder patients. On the day we visited this was 11 of their 34 beds. As a result, there were delays to timely reviews and accessing doctors.

At the time of our inspection service leads were developing new work to have associated wards between medicine and surgery. This allowed boarder patients to be in one place. They stressed the need for this to be owned by the pulling ward so that beds were filled appropriately. Both wards would identify suitable patients to be pulled into empty beds early to ensure 100% capacity. This involved the wards working together and education of the clinical aspects and knowledge required to work in partnership. This work would be implemented once approval was sourced. The service was waiting for the project group to agree a start date.

Staff did not always share key information to keep patients safe when handing over their care to others. A matron in recovery told us the service did not follow the national institute of care and excellence (NICE) clinical guideline (CG65) around ‘hypothermia: prevention and management in adults having surgery’ by not assessing patient’s risk of hypothermia, measuring or monitoring temperature, and devices for keeping patients warm before, during and after surgery. An operating department practitioner (ODP) told us they raised this with their band 7 who acknowledged they will take future action. ODPs worked with patients of all ages and were involved in each phase of a person’s operation.

Shift changes and handovers included all necessary key information to keep patients safe. We saw an audit of surgical handovers in general surgery from May 2019. This aimed to ensure local practice was compliant with the royal college of surgeons (RCS) guidelines. RCS guidelines stated surgical handover should include several components to be classified as safe handover. This used a sample of 40 patient cases admitted between 1-10 May 2019. Results found good
overall compliance to RCS guidelines for most indicators. However, the consultant name and location of patients were missed in a lot of cases. The surgical team discussed the audit findings at their governance meeting where junior doctors feedback the outcomes and agreed an action to ensure lists were compliant for daily handover.

Senior staff were visible on the day procedure unit (DPU) but staff told us they were not always supportive. They had a dedicated matron and a matron of the day.

**Nurse staffing**

*Nursing and support staff had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.* Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction. However, the service had less nurses and health care assistants than planned.

The service had enough nursing and support staff to keep patients safe. The service used the safecare system tool which aligned nurse staffing with patient acuity. This was reviewed three times daily and flagged the matron if staffing was short. Red flags aimed to raise awareness and communication around staffing levels with the matron of the day.

A log was kept of staff moved to other wards to ensure rotation. On the Cringleford ward a survey had been carried out among staff to find ways of making the process better for them. The survey found staff wanted to be called at home in advance if they were working on a different ward. The ward had since embedded this practice.

However, the service could not always safely staff the day procedure unit (DPU) ward areas. When this happened, they were required to close which reduced their capacity to admit, transfer, help recover and discharge elective patients. DPU’s risk register stated low staffing numbers and fatigue resulted in a risk of patient harm as a result of continual increased work load.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. For example, on the DPU wards service leads monitored staffing levels and allocation in advance to identify shortfalls as soon as possible. Service leads acknowledged they were unable to safely staff the DPU ward areas due to shortages. The service followed a ‘broken glass’ process a week before any staff shortfalls. However, at the time of our inspection the service’s current uptake was none.

The service divisions worked in line with the agency overtime and ‘breaking glass’ process for filling shifts. We saw the step by step guide for this revised ‘breaking glass’ process. The process began planning how to address unfilled shifts identified after the roster was produced and the matron had reviewed individual rosters for optimisation. The process detailed how extra shifts may occasionally be needed at short notice, such as for high acuity or staff sickness that could not be safely absorbed by team. In these cases, the matron ensured rapid progression and escalation of these steps was followed to ensure safe staffing at all times. If the responsible clinical manager felt their team could not operate without extra staff out of hours (OOH), they contacted the site operations team. However, the DPU ward was an exception area to this process so their agency requests and ‘break glass’ rates were sent every six weeks.

Managers had reallocated DPU staff where possible. For example, Saturday lists were cancelled with staff reallocated to the weekday shortfalls.

At the time of our inspection managers had recently reviewed Docking and Edgefield ward...
establishment numbers. They found Docking ward needed another nurse for day shifts. We heard Docking ward had also requested another nurse to cover night shifts. Edgefield’s budget would include an increase in nurses from April 2020 to ease staffing pressures.

However, patients on Docking ward told us there were not enough staff to care for them. This had an impact if more patients needed the support of two staff at a time. Bank staff would usually be arranged for patients who needed 1:1 care and treatment but this was not always possible. A student nurse on the Edgefield ward told us their learning was negatively affected by staffing. As a third year their leadership role had not progressed as they were still washing patients rather than supporting discharge.

At the time of our inspection Denton Ward had a significant number of inexperienced staff due to a high staff turnover following ward moves. Service impact was ongoing since ward moves in September 2018 but had worsened when the ward opened to full capacity due to winter pressures.

Gateley ward nursing staff told us there were not always enough staff on shift, but that it was always safe. They were required to work on other wards two or three times per month. This was monitored to ensure different staff were moved. Staff told us they felt supported by other ward staff when moved.

However, sickness on the Gateley ward was not always covered.

Nursing numbers were changed in response to acuity and patient risk. One member of staff told us if they had a number of patients needing extra care such as tracheostomies, their ward increased staffing numbers. At the time of our inspection the Coltishall ward staff were a nurse short, but told us they could mostly manage. Staff could red flag alerts using the patient alert system (PAS) if they were worried about staffing levels. If a patient needed one to one support, staff would assess them on admission and arrange bank staff.

**Trust level**

The table below shows a summary of the nursing staffing metrics in surgery at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Surgery annual staffing metrics</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>August 2018 to July 2019</td>
<td>July 2018 to June 2019</td>
<td>April to July 2019</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Annual average establishment</td>
<td>Annual vacancy rate</td>
<td>Annual turnover rate</td>
<td>Annual sickness rate</td>
</tr>
<tr>
<td>Target</td>
<td></td>
<td>10%</td>
<td>10%</td>
<td>3.9%</td>
</tr>
<tr>
<td>All staff</td>
<td>1,806</td>
<td>11%</td>
<td>9%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>662</td>
<td>12%</td>
<td>9%</td>
<td>4.8%</td>
</tr>
<tr>
<td></td>
<td>28,470 (7%)</td>
<td>20,831 (5%)</td>
<td>22,848 (5%)</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

The ward manager could adjust staffing levels daily according to the needs of patients.
Managers monitored ward staffing levels in real time using the safecare system tool. The director of nursing (DoN), or deputy DoN ensured actions were in place when required to reduce the impact of risk and other safe staffing concerns. At the time of our inspection the service had recently reviewed skill mix and establishment. The metrics for all staff shown above reflected the staff uplift in several areas. These percentages represented slight improvement since our last inspection when the annual vacancy rate was 11.4%.

The service had undertaken a three-month trial of self-rostering on the Docking ward. This resulted in increased staff satisfaction, staff retention and reduced management time used for health roster creation by 50%. However, the DPU risk register highlighted challenges in meeting roster compliance around skill mix. The DPU theatres and main recovery were assisting where skill mix and staffing allowed.

The service’s roster did not always meet the minimum staffing requirements. This had the potential to impact on the level of care given. For example, a reduction in experienced vascular registered nurses (RNs) meant Denton ward patients did not have their limb observations checked post bypass surgery. Patients had inappropriate dressings applied which led to wound breakdown. Dressings could also be too tight, meaning patient’s circulation was further compromised. These risks were highlighted on the ward’s risk register and the service had controls in place. Controls included ongoing recruitment process, education for new staff, and bank staff and overtime being utilised to fill roster gaps.

The service did not meet the trust target of 90% for publishing the E-roster with more than six weeks’ notice. From September to November 2019 this metric had only risen slightly from 30% to 32.9%. Service leads were developing safer staffing data using power business intelligence (BI). Power BI is a business analytics service which aims to provide visualisations and capabilities with an interface simple enough for end users to create their own reports and dashboards.

The number of nurses and healthcare assistants did not match those planned. We saw the division’s monthly safe staffing levels summary reports for June and July 2019. Of the nine surgical wards in June 2019, six wards or two thirds of the total had 15 or more day shifts where actual nursing or midwife staff numbers fell below those planned. The highest number of these day shifts was 11 on Coltishall ward. This number rose to 30 shifts for July 2019. This meant Coltishall ward staff only achieved 86% of day shifts hours worked when compared to those planned.

The highest number of night shifts which was four occurred on the surgical emergency assessment unit (EAUS) or Easton ward. EAUS also had the most red flags in June 2019 with 16. Cringleford ward had the most day shifts where actual health care assistants (HCA) numbers fell below those planned, with 11. By July 2019 the Gateley ward had 13 day shifts where actual HCA numbers fell below those planned. The workforce information team calculated the service’s total care hours per patient day (CHPPD) lost by unsafe staffing levels.

The service was planning for more staff than it could deliver. As a result some wards had been approved a nursing staff uplift. The service had distributed a new incentive poster to all surgical wards encouraging staff to undertake overtime on DPU ward areas.

Nurse staffing rates within surgery were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and sickness. The trust only provided data on bank use and agency use for four months and therefore analysis of change over time was not possible.

**Vacancy rates**
The service had low and reducing vacancy rates.

The DPU ward areas staffing shortage were a result of a band 5 vacancy position (7.55 WTE) and a band 6 vacancy position (1 WTE). The DPU ward were established for 34 WTE band 5/6 staff.

At the time of our inspection the service had a 33% shortfall on vacancies as five staff were on maternity leave; two band 6s and three band 5s. The service were advertising for these vacancies with recruitment. We saw that DPU was at a 48% vacancy rate with maternity and sickness included. This risk was highlighted on their ward’s risk register.

The service planned to cover the interim period to support current staffing vacancies. Service leads booked agency staff for two months until the recruitment process was successful and new staff were embedded.

At the time of our inspection Denton Ward had a high vacancy rate due to turnover. This was 10.24 WTE reducing to 8.24 by the end of January 2020 but these were still inexperienced staff.

Service leads were running a full ward with a 50% vacancy rate for registered and unregistered staff. This risk was highlighted on the ward’s risk register.

The service planned for the Edgefield urology ward to be fully established to the required number of staff following an establishment review. The matron was involved in the trust’s overseas recruitment programme. Two overseas nurses joined the urology team between November 2019 and January 2020 who were being inducted in a supernumerary period. Senior staff offered student engagement for first post qualified (FPQ) nurses. The management team planned to attend a recruitment-based event to promote the ward.

At the time of our inspection the service were recruiting 100 registered nurses overseas using a second agency with a team currently in India. Since our inspection, we received evidence from the trust that vacancy rates had reduced to 7.3% by February 2020. This was equivalent to a 63.5 WTE vacancy reduction.

![Vacancy rate - qualified nurses, health visitors and midwives](image)

Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives showed a downward trend from August 2018 to December 2018 followed by an upward trend from December 2018 to April 2019, although this did not continue.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)
Turnover rates

The service did not have low and reducing turnover rates. The service discussed DPU staff shortfall with human resources (HR) to implement and improve exit interviews. This helped them identify any thematic issues for high turnover.

At the time of our inspection the service were working with HR and recruitment to try and fill interventional radiology (IR) vacancies. Senior staff had visited a recruitment fair in October 2019 but found no suitable candidates. Two band 6 clinical educators, one band 6 nurse, and three band 5 nurses had been recruited since the previous month. The divisional recruitment lead had started to support IR unit recruitment.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

The service did not have low and/or reducing sickness rates. The service’s DPU ward areas had two staff on long term sick. Their staffing sickness rate for July 2019 was 8.3%.

At the time of our inspection staff sickness in the service had increased. For example, a senior staff member was given last minute annual leave due to stress.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

The service did not have low rates of bank and agency nurses. The service had an ongoing recruitment process and education for new staff. Bank staff and overtime were being utilised to fill gaps in the roster. As a result, the DPU risk register highlighted an increase in agency spend and overtime.

Managers limited their use of bank and agency staff. Service leads recruited staff who wanted to work on the ward straight from the bank using the fast-track process. Bank and agency nursing staff were used less for nursing than for HCAs on the Gateley ward.

Managers requested staff familiar with the service. At the time of our inspection the service had a rolling vascular specific advert, as they had no applicants for the last two cycles. Service leads had organised a vascular recruitment day before the ward moves which only had four attendees. They were also working with the matron teams to offer secondments to staff from other areas.

Managers made sure all bank and agency staff had a full induction and understood the service. Bank staff were contacted via text message for shift opportunities and new orientation shifts were offered to increase uptake.

Agency staff undertook inductions and had the required skills. However, we heard regular paediatric agency and bank staff had lost the commitment to work in DPU as procedures were often cancelled. We also heard agency staff could not always access certain IT systems to check patient’s blood test results. This meant there could be delays to patient’s follow up treatment on wards with agency staff.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Medical staffing
The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. The service had an annual vacancy rate of 4% for medical staff between August 2018 and July 2019. Managers ensured there were enough medical staff to safely care for patients at all times. The divisional leadership team reported they faced challenges with the attraction of new medical staff due to the geographical area and the attraction of working at a regional hospital nearby. The division had an ongoing recruitment drive in place to address the issue with recruitment of medical staff.

Managers could not always access locums when they needed additional medical staff. They booked locum doctors to fill vacant shifts for medical staff. The service filled medical staff vacancies with planned long-term locums in advance. Managers could also arrange locum staff for short notice cover. However, information provided by the trust shows 3% of medical staffing shifts were still unfilled between April and July 2019. This meant managers could not always access locums to cover unfilled shifts.

Managers made sure locums had a full induction to the service before they started work. The trust had a locum induction programme in place. All locums had to complete an induction programme before they started working at the trust.

Staff completed daily clinical utilisation reviews and red2green ward meetings. We observed an red2green multidisciplinary team (MDT) meeting on the elective orthopedic ward which had no medical staff attend. However, this was not necessary given the skill mix of other nursing and allied health professional (AHP) staff.

The service’s medical staff carried out ward rounds at least daily to support all patients. Patients with any additional needs and identified risks were discussed at a daily safety huddle. Staff discussed high risk patients more frequently.

However, without at least twice daily huddles to update staff there was a risk they could not always respond to deteriorating or rapidly changing patient’s safety plans in time. This meant the service relied on individual staff to identify high risk patients admitted later in the day and communicate concerns effectively across the team.

Please note that the trust informed us that some of their anaesthetics staff at Norfolk and Norfolk University Hospital have merged workloads with the critical care team. Therefore, the staffing analysis below includes some staff working across surgery and critical care.

Trust level

The table below shows a summary of the medical staffing metrics in surgery (and critical care) at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Surgery (and critical care) annual staffing metrics</th>
</tr>
</thead>
<tbody>
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<td>August 2018 to July 2019</td>
</tr>
<tr>
<td></td>
<td>Annual average establishment</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------------------</td>
</tr>
</tbody>
</table>
The medical staff did not match the planned number. We saw consultant job planning rates from September to November 2019 had risen from 14.9% to 32.2%. However, this was still well below the trust target of 90%.

Medical staffing rates within surgery (and critical care) were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, and sickness. The trust only provided data on bank use and locum use for four months and therefore analysis of change over time was not possible.

**Staffing skill mix**

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The service’s Edgefield ward planned for consultant ward round teaching and time for a new starter to shadow the on-call team. To action this the consultant body were encouraged to be engaged in ward round teaching. This was discussed at governance meetings in September 2019. Any new starters were given time to shadow the on-call team to enable understanding of the urological conditions which present as emergencies. However, at the time of our inspection this was not happening regularly.

In July 2019, 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 lower.

**Staffing skill mix for the whole-time equivalent staff working at Norfolk and Norwich University Hospitals NHS Foundation Trust**

<table>
<thead>
<tr>
<th></th>
<th>Consultant</th>
<th>Middle career</th>
<th>Registrar Group</th>
<th>Junior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>55%</td>
<td>7%</td>
<td>27%</td>
<td>10%</td>
</tr>
<tr>
<td>Hours available</td>
<td>50%</td>
<td>11%</td>
<td>28%</td>
<td>11%</td>
</tr>
</tbody>
</table>
Records

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

Patient notes were not always comprehensive, but all staff could access them easily. We reviewed 12 sets of patient notes. We found the service’s records were not always completed fully and were sometimes difficult to navigate. For example, intentional rounding was incomplete in two records we checked. One set of notes for a patient with vasculitis had no sepsis screening form, no allergies documented and medicines were given late as the trust’s prescribing system was ‘not accurate’ for pharmacy review.

Nursing care plans, malnutrition universal screening tools (MUSTs), fluid charts, Waterlow, manual handling and falls assessments were completed in all patient records we checked. However, we found the falls assessment proforma did not use a multi-factorial approach so was not comprehensive. There were only standard generic care plans for patients with a low, moderate or high risk of falls. This meant staff were unable to identify where patient care was required.

We found no date on one patient care plan although the date was circled. A nurse on Edgefield ward reported the service’s regular audits highlighted poor standards of record keeping as many were unsigned with dates and times missing.

Record trolleys were often left unlocked. We saw open and accessible records next to the patient waiting area on the same day admissions unit. We saw a further set of records left unattended on a table away from the nurses station. This meant there was a risk to patient’s confidential medical information.

Edgefield ward were undertaking measures to improve their documentation via an audit. Their
next steps were to encourage both medical and nursing staff to ensure all pages were clearly labelled and page numbers applied, ensure all staff write clearly and include their contact number, and to ensure all documentation is kept out of sight when not in use to protect confidentiality.

When patients transferred to a new team, there were occasional delays in staff accessing their records or paperwork during handover.

Records were not stored securely. We saw records trolleys on multiple wards were left unlocked which we could open unchallenged by staff. Patient records were also left out open when not in use. Radiology inpatients notes were not always secure within a blue zipped bag as required. We saw blue nursing folders which were randomly placed and unidentifiable from the outside. An NRLS incident reported in June 2019 found that within one week 105 inpatients notes were not secure across almost all surgical wards.

**Medicines**

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

Staff did not follow systems and processes when safely prescribing, administering, recording and storing medicines. We found specific incidences of poor medicines management across the service. This included poor ambient and fridge temperature monitoring, expired stock and missing controlled drugs.

**Recording and storing**

In main theatres medicines were not always recorded correctly due to signature gaps. For example, we saw several controlled drugs (CD) register errors for morphine, fentanyl and ketamine. These were administered or discarded without amounts, signatures or witness signatures. Despite this, two staff members had cross-checked and signed afterwards to state there were no discrepancies.

The service’s day procedure unit (DPU) recorded a weekly audit of minimum and maximum fridge temperatures.

We read the service’s fridge and ambient temperature compliance monitoring had improved over December 2018 across all theatres and recovery. However, service leads noticed the same minimum/maximum results for several consecutive days. As a result, they reminded staff in the monthly newsletter with instructions to reset these daily and report any erroneous results in line with the trust’s medicines policy and procedures. They also reminded staff which items must not be stored with medicines in refrigerators.

We checked the drugs fridge and room temperature recording in recovery which had no gaps or oversights. Recovery also had no gaps in their CD register. There were very few incidences where CDs were discarded.

The service checked controlled drugs (CDs) weekly. However, occasionally on the Edgefield ward these checks were missed or delayed for up to 12 days in a row. Where CD checks were carried out, operators failed to record the quantity. This was amended on the day of our inspection. Patient’s own CDs were kept with the ward stock, despite the nursing and midwifery council’s (NMC) standards for medicine management guidelines stating they need to be segregated.

The thermometer was not being reset after each check. Ward staff lacked the knowledge about how to reset this, despite a helpful guide available on fridge doors created by pharmacy. A
number of medicines were out of date. For example, acetone expired in May 2019. Other expired medicines were diazepam 5mg rectal, videne scrub and hibiscrub. Single use medicines such as a part bottle of acetic acid (5%) used in November had been returned to stock.

Medicine records were inconsistent on Docking ward. CDs checks showed a shortfall of four fentanyl ampules and the drug chart recorded patient doses. However, there was no CD register entry to show the used fentanyl. The CD cabinet was being used as a medicine cabinet rather than for its intended purpose. Ambient temperatures over a period of five months from 27 July 2019 up to and including 20 November 2019 for maximum and minimum reads were 32.7 degrees. We reported this anomaly to the pharmacy department who changed the thermometer. However, they took no documented evidence to investigate these issues. This meant no actions would be taken or learning shared to prevent future occurrence.

The service shared incident learning in June 2019 after being supplied with fentanyl which was labelled and packaged “this product is not licensed for use in the UK”. Pharmacy were unable to maintain a supply of fentanyl from their regular supplier. As a result, they ensured fentanyl was available to maintain service provision by purchasing from Germany. Pharmacy quality controlled and assured the service it was safe to use. They added an extra sticker to boxes for outsourced medicines to confirm this. Staff were asked to continue raising any doubts or concerns over medication or consumables and their safe use.

The fridge was wrongly loaded with medicines touching the sides, trays on shelves and item stored on the base of the fridge. This did not allow enough airflow around medications and could affect medicine temperatures.

We found two ampules of pulmozyme nebulus for cystic fibrosis patients under the refrigerator. Lidocaine and prilocaine gel had expired in August 2019. We also found a separate storage clean utility with fluids but no ambient temperature monitoring. Numerous suppositories were out of their original packing on the bottom fridge tray with miscellaneous items.

Edgefield ward had recently introduced red apron tabards for nurses to wear during drug administration rounds. This minimised the amount of interruptions causing drug errors.

Staff reviewed patient’s medicines regularly and provided specific advice to patients and carers about their medicines. The service had a ward-based pharmacist who deal with all the tablets to take home (TTOs). A daily pharmacy clinic was available for patients using polypharmacy.

Staff did not always store and manage all medicines and prescribing documents in line with the provider’s policy. The service used an electronic prescribing and medications administration (EPMA) system. Service leads reported repeat incidents in June 2019 where patients were double dosed as a result of not checking EMPA before administration. No patients were harmed as a result. In response service leads reminded theatre and recovery staff to check EMPA before administering any medications or siting an epidural/spinal. They were looking at and trialling hardware to improve the ease and speed of access to EMPA.

We inspected 3 controlled drugs (CD) registers in theatres. Discarded amounts of CDs had not been witnessed or cross-signed which was not fully compliant.

Staff followed current national practice to check patients had the correct medicines. We observed staff administering medicines on the wards, they checked medicine prescription, allergies, dosage and patients’ wrist identity bands against the prescription chart before they gave patients their medicines.
The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The service implemented the wearing of disposable red aprons for nurses while undertaking medication rounds. This allowed for easy identification by hospital colleagues that the nurse should not be disturbed unless in an emergency. This helped prevent interruption and reduce the number of medication related incidents. The use of disposable aprons was identified as this controlled infection risk, was cost effective and quick to implement.

The service had appointed a pharmacy link for theatres and recovery from October 2019.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. One patient being administered codeine was asked how many they would like and was not informed this would affect their bowel.

Incidents

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

Not all staff knew what incidents to report and how to report them. At the time of our inspection the service had a new internal incidents reporting system and all staff had login details. Staff adhered to a new process of receiving feedback on incidents they had reported. Overall staff told us the number of incidents they reported had increased as the process was easier. Staff told us they received feedback on any incidents they had reported. Once incidents had been investigated they were shared with the wider team. An example of a common incident category nursing staff reported were falls. A patient flow coordinator told us incident reporting in the day procedure unit (DPU) had risen. As they had good communication with pre-operative staff they were encouraged to troubleshoot, show trends and audit risk.

Incident reporting was raised as an action for improvement on our last inspection.

The service’s top three serious incidents were delays in treatment causing harm, category three or four hospital acquired pressure ulcers (HAPUs) and falls on the ward resulting in moderate harm or requiring surgery. HAPUs were discussed at the essential care scrutiny group (ESCP). The service had carried out a life QI project in August 2019 to reduce the number of HAPUs in patients coming from the same day admissions unit (SDAU) undergoing surgical procedures in theatres by 25% by September 2020 (within a year). This led to a reduction in HAPUs and improved skin integrity for patients.

The ESCP reviewed pressure ulcers categories two, three and four, inpatient falls where the patient had experienced moderate, severe harm or death and safeguarding incidents.

Band 6 nursing staff had been trained to investigate incidents. Themes were discussed at monthly ward meetings. A paediatric nurse in the DPU gave us recent examples of reported incidents. These were occasional medicines errors and pre-operative issues, for example failure to stop thrombolysis. In response the service had completed a re-audit of thrombosis risk assessment (TRA) completion for day cases in DPU from January 2019. The re-audit found patient classification was always documented by staff. Staff assessed risk factors and documented anti-embolism stockings in more than 90% of cases. However, staff only documented the risk of anticoagulation in 67% of cases. The re-audit results were reviewed with the pre-operative nursing team to ensure they were aware of the need to complete every step. The service’s process for
TRA changed in April 2019 with updated guidelines and proposal for EPMA for day cases. They planned to re-audit once changes were embedded.

The service had a monthly newsletter called Gauzette with learning for theatres and recovery. We saw learning feedback following a reported incident in January 2019 involving drugs in the wrong drug box identified and not given. As a result, staff were reminded they needed to ensure drugs were not taken out of their packing unless needed and if not used, to be returned to their original packaging. Drugs ampules and vials must not be stored, left loose or in the wrong packaging to reduce the risk of the wrong medication being administered.

At the time of our inspection the service’s number of medication incidents had increased on vascular wards. For example, there were only two during October 2019 but seven in November 2019. We read about two medication error incidents on the Edgefield ward over the August 2019 bank holiday. One patient was sent home without an electronic discharge letter (EDL) and was unsure which tablets they needed to take. EDLs contain details of medicines that patients are prescribed. After reviewing the tablets to take home (TTO’s) from discharge and discussing with the assistant practitioner, the patient was sent home with no furosemide tablets (40mg). The patient had none in stock at home as was stated when they were admitted to hospital. The other incident was a drug error made when staff looked at the wrong patient prescription chart on the electronic prescribing and medications administration (EPMA). Both incidents were shared with the patient safety team and discussed at the significant incident group (SIG) in August 2019 where they were reduced from low to no harm.

Service leads were aware of trends and themes from reported incidents. For example, in main theatres during January 2019 they explained the specimen room and formalin pump was trending as a thematic issue. This had been left on a flow rate of 400. As a result, they sent staff a reminder email to reduce the rate after use and check rate prior to use. They also placed new instructions in the room to reflect this and contacted the company for post sales advice on accessories available to reduce the risk of splashing and spillages.

However, the service did not always share learning from incidents. One staff member said they only heard about learning from other staff. Two registered nursing staff we spoke to did not know how to report incidents so they would seek help from colleagues.

We saw evidence in the service’s incident investigations duty of candour (DoC) was applied. DoC meant a health service body must notify patients a notifiable safety incident has occurred as soon as possible after becoming aware. They should provide reasonable support to the relevant person in relation to the incident and offer an apology. However, the service’s DoC compliance by informing patients from September to November 2019 was below the trust target of 95%. This was getting worse and dropped to 62.5% in November.

Staff did not always raise concerns and report incidents and near misses in line with trust/provider policy. The service held a daily significant incident group (SIG) attended by the director of nursing (DoN). If staff reported an incident they could attend the group. When staff were directly involved in an incident they were told the outcome. Incident information was put on ward noticeboards and emails were sent out to inform staff.

The service did not meet the trust target of resolving reported incidents within 14 days. The number of overdue incidents from September to November 2019 was over twice the target of 426, with 854 in November.

Edgefield ward staff told us they had several preventable incidents over August 2019’s bank holiday weekend whilst caring for a very high number of acutely sick patients. We followed this
up and requested the service’s safecare reports for the August bank holiday weekend. They showed Saturday staffing levels were less than required to support patient acuity. The service clarified they had no serious incidents reported that weekend but seven incidents causing moderate, low or no harm. This number of reported incidents at a major acute hospital was normal over three days but the trust took prompt action. Their chief nurse invited Edgefield to present their data regarding no/low incidents and pressure ulcers to a chief executive oversight (CEO) assurance panel. This panel occurred on 25 September 2019.

Edgefield Ward saw a period of increased sub-optimal care incidents raised from May to August 2019. This caused service leads increased concern during SIG meetings. The service adopted a team approach to the investigation panel, which included nursing staff and the governance lead for urology. We saw numerous ongoing actions were taken by ward staff in response to these concerns. These included feedback from all reported incidents in monthly huddles, an establishment review based on safecare data, an increased band 6 establishment, an accurate safecare reflection of managerial/clinical time and support to achieve 100% safecare compliance.

Never Events

The service had never events on wards. 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.

From October 2018 to September 2019, the trust reported two never events (NEs) for surgery, both of which occurred at Norfolk and Norwich University Hospital. We saw completed route cause analyses (RCAs) methodology was applied for these NEs in accordance with the former national patient safety agency (NPSA) and NHS England’s recommended best practice guidance for carrying out incident investigations.

The first NE incident took place in November 2018. This incident involved the wrong side nerve root block injection under sedation. We followed this up on inspection. A full RCA investigation was carried out by a consultant anaesthetist-led team. The service highlighted two route cause findings as the patient was not side marked before leaving the ward and during the WHO checklist no final check of the correct side was made by theatre staff. Their lessons learned were poor scheduling and organisation, inadequate secretarial support as the clinic and duty of candour (DoC) letters were delayed. They also found not all relevant clinicians sharing the list were available and there was no pre-safety briefing. As a result, the service had made detailed recommendations around marking the side of the procedure as per NPSA checks and the WHO surgical safety checklist.

The second NE incident took place in June 2019. The incident involved a patient that was mistakenly administered medication by the wrong route as they were infused with 250 milligrams of intravenous (IV) levobupivacaine instead of with IV ciprofloxacin. We followed up the June incident with Docking ward staff who told us this occurred because different medications in similar packaging were stored next to each other. The stockroom had been rearranged as a result. Both staff involved had been supported to refresh their IV training. All staff involved attended a full debrief with support from the chief nurse and the patient was kept in the high dependency unit (HDU) overnight. Service leads discussed the incident at their daily serious incident group (SIG) meeting. The pharmacist involved followed duty of candour by sending the patient and their next of kin a letter with a verbal apology and PALS leaflet.

The service had a third NE a few weeks before our inspection in December 2019. This incident
involved a midline insertion in vascular access where staff did not ensure a patient ID check on the device assessment and insertion form completed with the practitioner pre-operatively as per World Health Organisation (WHO) guidelines. The service took immediate actions outlined in the RCA with advice sought from all staff involved on the next steps. For example, service leads added an ID check onto the vascular device assessment and insertion form. This would be completed in the presence of the vascular access practitioner before the procedure commences.

(Source: Strategic Executive Information System (STEIS))

Managers shared learning about never events with their staff and across the trust. RCA investigations had a section called ‘arrangements for shared learning’. RCAs were shared with the relevant chief of division, divisional nurse director and divisional operational director for dissemination to their teams and action plan monitoring.

Breakdown of serious incidents reported to STEIS

Staff reported serious incidents clearly and in line with trust policy. From 1 January to 31 July 2019 the third highest number of the strategic executive information system (STEIS) incidents trustwide occurred in surgical specialties (13.1%). STEIS is a system which facilitates the reporting of serious incidents and the monitoring of investigations between NHS providers and commissioners. The most common incidents were treatment delays, sub-optimal care of the deteriorating patient and pressure ulcers.

During the same six months, the third highest number of national reporting and learning system (NRLS) incidents trustwide occurred in surgery (19%). NRLS is a central database of patient safety incident reports. Since being set up in 2003, the culture of reporting incidents to improve safety in healthcare has greatly developed. The most common incidents were implementation of care and ongoing monitoring and review (25.1%), patient accident (17%), treatment/procedure (11.2%).

Service leads asked staff to report all deaths within the theatre and recovery environment on the trust’s incident reporting system. This was emphasised in the monthly newsletter. They explained this helped them learn from the event, acknowledge any thematic trends and recall as much information as possible from the time of the event for subsequent mortality and morbidity reviews.

The service knew how to escalate and incident report pressure ulcers (PUs) in accordance with SI criteria. However, the service did not meet the trust target of 90% for SIs responded to within 60 days. From September to November 2019 this target was only met for October with 0% in September and 50% in November.

Trust level

In accordance with the Serious Incident Framework 2015, the trust reported 28 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from October 2018 to September 2019. All incidents occurred at Norfolk and Norwich University Hospital.

A breakdown of incidents by incident type is below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>8</td>
<td>28.6%</td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>6</td>
<td>21.4%</td>
</tr>
<tr>
<td>Event Type</td>
<td>Count</td>
<td>Percentage</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>-------</td>
<td>------------</td>
</tr>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>3</td>
<td>10.7%</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient meeting SI criteria</td>
<td>3</td>
<td>10.7%</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident meeting SI criteria</td>
<td>2</td>
<td>7.1%</td>
</tr>
<tr>
<td>Medication incident meeting SI criteria</td>
<td>2</td>
<td>7.1%</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI criteria (including failure to act on test results)</td>
<td>1</td>
<td>3.6%</td>
</tr>
<tr>
<td>VTE meeting SI criteria</td>
<td>1</td>
<td>3.6%</td>
</tr>
<tr>
<td>Apparent/actual/suspected self-inflicted harm meeting SI criteria</td>
<td>1</td>
<td>3.6%</td>
</tr>
<tr>
<td>Abuse/alleged abuse of adult patient by staff</td>
<td>1</td>
<td>3.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>28</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. Once the service’s two NE incidents were detected, surgeons gave an immediate apology to the patient with reassurance that a full RCA investigation would take place. Throughout the wrong side nerve block injection and the following correct sided procedure, the patient and family were fully updated.

We heard an example of duty of candour being applied where a surgeon on the Cringleford ward had accidentally ‘nicked’ the sciatic nerve during a procedure. The nurse was asked to support the patient while the doctor explained to them what had happened.

We saw service leads had emphasised duty of candour in January 2019’s monthly theatres and recovery newsletter. This reminded staff of the need for every healthcare professional to be open and honest.

Staff received feedback from investigation of incidents, both internal and external to the service. A summary of learning from all SI reports was provided at monthly clinical governance leads meetings and matrons and ward sister’s meetings. Learning from SI’s was also reported through the SI and incident reporting OWLs (organisational wide learning sheets).

On the Edgefield urology ward a sister told us they got feedback from incidents. They gave the example of an orthopaedic patient who had been administered the wrong medication so staff were now more careful and had to doublecheck which led to improved oversight.

Staff met to discuss the feedback and look at improvements to patient care. All divisional staff were encouraged to attend the daily serious incident group (SIG) which shared learning and feedback. These groups facilitated open themed discussions chaired by an executive where anyone could present a SI from the incident reporting system to assess DoC, the level of harm and how widely learning should be shared. Patient care and safety improvements were considered even from incidents categorised with no or low harm. For example, venous thrombosis (VTE) medication errors were scrutinised to help future awareness and stock security.

The group’s core attendees were the director of nursing, chief nurse and a risk team representative but specialist groups could also attend. The ward or deputy sister with matron support planned time to allow Edgefield staff to be released from the ward to attend SIG.

A urology ward sister explained slips, trips and falls were their most common incidents. As a result, staff had made environmental changes to reduce clutter and any possible trip hazards.

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There was evidence that changes had been made as a result of feedback. For example, we heard changes in DPU arose from an incident where a patient collapsed in the Reedham ward where bays were too narrow so staff could not access oxygen. There was also a lack of oversight if mental health patients wished to self-harm. As a result, this ward was no longer used for escalation.

Service leads shared changes made and best practice from incident learning with theatres and recovery staff in all monthly newsletters. For example, staff were reminded to pass hypodermic needles inside a kidney dish receiver and once used, the operating practitioner should close the safety mechanism to make the hypo ‘safe’.

Managers investigated incidents thoroughly. Patients and their families were not involved in these investigations. The essential care scrutiny panel (ECSP) weekly forum reviewed completed route cause analysis (RCA) documents for various incidents. The service’s incident reporting team identified new patients for the panel, as well as from the tissue viability and safeguarding teams through their incident reporting system. The panel’s process was outlined in the trust’s incident management and investigation policy and procedure.

Service staff from many areas presented their incidents to encourage shared discussions and learning within a safe environment. Where spikes in incidents were identified, teams were supported with a separate thematic review. In some cases, this led to teams starting a quality improvement project (QIP), or sharing learning from other QIPs. The themes of root causes and learning outcomes were shared through the senior practitioner forum with updates shared at the patient experience and engagement group (PEEG).

However, we reviewed samples of panel notes from their last three meetings and found an RCA was incomplete. This meant it had to be reviewed and returned to a future panel. Another route cause stated the patient risks were unclear from staff’s inconsistent documentation. This meant review panel staff were unsure if the patient got what they needed.

Managers debriefed and supported staff after any serious incident. We read about an incident in June 2019’s monthly newsletter where during a laparoscopic procedure the CO₂ cylinder ran out and needed to be changed. When the circulator went to change the cylinder, somebody had accidentally placed a medical air cylinder on the stack as the spare. There was a delay in surgery whilst a new CO₂ cylinder was sourced. Due to the pin index system, it would not have been possible to connect the incorrect cylinder to the stack and although no patient harm occurred – there was a delay during the surgery. Service leads reminded staff to check the gas cylinders on the lap stack as part of their safety checks on the equipment before use.

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Safety thermometer data was displayed on wards for staff and patients to see. The service used perfect ward to measure compliance. Perfect ward scores on the Edgefield ward were 95% for October 2019. The service also undertook weekly perfect ward audits. Service leads told us these audits set the bar at 80% or more and were very thorough. Audits were easier to complete via a tablet device system which ensured there was more uptake than if they were completed on paper.

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.

Patient safety thermometer data showed the trust reported 34 new pressure ulcers, 18 falls with harm and ten new catheter urinary tract infections from September 2018 to September 2019 for surgery.

The safety thermometer data showed the service did not achieve harm free care within the reporting period. The service achieved three months of harm free care from September 2018 to September 2019 with a total of 18 falls. Between January and April 2019 the service had 1.2 falls on average with harm levels between three and six. The information in the charts below demonstrates this.

The safety thermometer showed the service had reduced the incidence of harm within the reporting period. The total number of pressure ulcers (PUs) graded two, three and four from September 2018 to September 2019 had fallen from 1.5 per month to 0.5.

The service had carried out a life quality improvement (QI) project in February 2019 on reducing the number of PUs caused by casts. Another life QI project was undertaken to reduce the number and occurrence of PUs on high risk vascular patients admitted to the Denton ward.

Staff used the safety thermometer data to further improve services. Data collection took place one day each month – a suggested date for data collection was given but wards could change this. Data had to be submitted within ten days of the suggested data collection date.

Staff we spoke to knew the importance of completing Waterlow charts on admission and every three days. They understood the need for pressure relieving air mattresses and cushions if patients were assessed as high risk of tissue damage. Staff gave patients and families advice leaflets. However, pressure ulcer advice and guidance was poorly documented in patient’s notes. We saw several RCAs reviewed by the ECSP found patients had a lack of adequate skin inspection and documentation.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at Norfolk and Norwich University Hospitals NHS Foundation Trust

![Graph 1: Total Pressure Ulcers (34)](image)

![Graph 2: Total Falls (18)](image)
Total CUTIs (10)

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital)
Is the service effective?

Staff always had access to up-to-date, accurate and comprehensive information on patients’ care and treatment. All staff had access to an electronic records system that they could all update.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed NICE guidance. Staff protected the rights of patient’s subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service ensured surgery was managed in accordance with the association for perioperative practice (AfPP) principles. For example, service leads reminded staff that swabs must not be cut, wilfully damaged or divided into two or more pieces. The AfPP works to enhance skills and knowledge within operating departments, associated areas and sterile services departments.

The service ensured daily observations on the Edgefield urology ward and had actioned a fluid balance charts (FBC’s) audit. However, audits were not happening frequently. Service leads encouraged all staff to check fluid and observation charts on every handover to ensure information was passed on.

The service’s Cringleford elective orthopaedic ward had enhanced recovery pathways for patients having primary hip and knee replacements. The trust launched the Norwich Enhanced Recovery Programme (NERP) in 2011 focusing on the provision of safe and effective analgesia. This was done by a multimodal programme with minimal side-effects which enabled earlier patient mobility and discharge. The service had reduced patient’s length of stay (LoS) significantly from adopting the NERP. In 2018 their average LoS for both hip and knee replacement surgery had fallen to four days from eight days in 2010. This showed improved patient satisfaction feedback and reduced risks of infection and thromboembolism.

The service had carried out a quality improvement (QI) life project in March 2019 to standardise safe handover for emergency obstetric patients. This improved handover quality between the midwifery, obstetric theatre team and safety of patient transfer for all non-life threatening emergency obstetric cases by 80% before 31st January 2020.

However, some patients on the day procedure unit (DPU) were inappropriately referred and selected outside the standard operating procedure (SOP). For example, patients with abdominal pain, IV antibiotics or maxillofacial with a drain would not be ready for discharge the next day.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We observed a red to green handover meeting on the Cringleford ward. Multidisciplinary team (MDT) staff discussed and considered the mental and psychological health needs of all ward patients.

The service’s Edgefield urology ward staff carried out a safety brief twice daily at shift handover. This was in response to increased sub-optimal care incidents raised in a four-month period between May and August 2019.

Nutrition and hydration
Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other needs.

**Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.**

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Catering staff visited DPU often to offer patients hot meals and drinks. Patients told us there was a good choice of food available. They got what they ordered and it was hot enough. Water was topped up frequently and hot drinks were offered. For example, we spoke to a patient who was given a hot drink upon arrival in the discharge suite. Another patient we spoke with was underweight so staff were monitoring this.

We saw protected mealtimes were in place on wards and were adhered to by relatives and staff. Protected mealtimes is an intervention developed to address the problem of malnutrition in hospitalised patients through increasing positive interruptions (such as feeding assistance) whilst minimising unnecessary interruptions (including ward rounds and diagnostic procedures) during mealtimes.

However, senior staff and the patient services had identified a lack of tea, fruit and water rounds to some areas.

Patients were able to receive nutrition by other means if their condition required it. We saw patients receiving nutrition through enteral feeding as well as those requiring total parenteral nutrition intravenously.

Staff fully and accurately completed patient’s fluid and nutrition charts where needed. We reviewed 12 sets of patient records. Of these seven patients had fluid balance or food charts. Staff had completed the charts and we saw the fluid balance charts had been calculated correctly.

The service planned to adapt RCA documentation to improve exploration of how well nutrition and hydration needs of patients were being met. They also planned to trial the development of a nutritional care RCA document.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We saw fully and accurately completed malnutrition universal screening tool (MUST) forms in all patients records we checked. MUST is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.

However, we read the service’s ECSP update which listed themes for improvement. These included delayed or missing food charts and delays in staff completing MUSTs due to over reliance on the MUAC assessment.

Specialist support from staff such as dieticians and speech and language therapists was available for patients who needed it. We checked speech and language therapist documentation in patient’s notes for patients on a modified or restricted diet. These were recorded within the daily nursing assessments. Any relevant diet boards were clearly visible above patient beds.

We saw the ECSP’s positive findings and learning around nutrition. The service could evidence good practice in areas with dedicated dietician support or where patient groups were known to have nutrition-related risks. Dieticians supported improved challenge and learning through the panel and completion of SIs. Dieticians were also keen to work with the tissue viability nurses.
(TVNs) and clinical teams to support staff education.

However, the panel update’s themes for improvement included delayed referral and review to dieticians.

Patients waiting to have surgery were not left nil by mouth for long periods. The service had a fasting policy. Staff clearly identified patients who were nil by mouth and followed trust guidelines for their management. For example, patients entering theatre were offered 30ml sips of water hourly until the time of their surgery. Staff gave patients waiting longer intravenous fluid therapy (IVT).

**Pain relief**

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

Staff assessed patient’s pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients were asked if they were in any pain. Nursing staff we spoke to had good understanding of pain management and the pain team referral process. Ward staff we asked knew how to contact the pain management team when needed. For example, we saw staff had communicated well with the pain management team in route cause analyses (RCAs) from never events (NEs). We saw patients receiving pain management in a number of ways including patient controlled analgesia. Post-operative pain management plans were made ahead of the procedure.

Patients received pain relief soon after requesting it. The majority of records we checked showed staff managed patients medicines in a timely manner. However, one patient on the Docking ward told us they had stressed the importance of needing timely pain relief and staff did not follow this up so they had to ask again. This meant the patient had a five minute delay with a very painful entry point.

Staff prescribed, administered and recorded pain relief accurately. Medicine prescriptions records we reviewed showed staff prescribed appropriate pain-relieving medicines at regular intervals during the day and extra medicines for any break through pain. We observed staff had administered pain relieving medicines to patients as they had been prescribed.

**Patient outcomes**

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. At the time of our inspection the service had achieved 100% compliance with anaesthetic clinical standards accreditation (ACSA) standards. The service also had a new structure in place from early 2019 to meet sterile services department accreditation. This included an additional deputy manager to fulfil both operational and quality-focused duties. The service had a yearly external audit and accreditation. In September 2019 this had improved to show no major and seven minor findings, with no risks to patients or product identified.

The service carried out WHO theatres and surgical compliance audits. We saw an observational audit of surgical safety checklist compliance. To ensure compliance the recording of this audit changed from the trust’s electronic theatre database to a paper document which formed part of the patient’s notes. This was part of an ongoing surveillance audit from August 2018 to determine...
compliance and identify areas that may require improvement. Results showed good compliance of the sign in, time out and sign out documentation times. This audit was followed up with a key action as a new debrief document and process was implemented.

The service published all their audit results on the trust’s shared drive and intranet. They were also sent to the deputy divisional operations director for surgery, the inpatient theatre matron and the theatre administrator. They were then disseminated to the theatre management group, director of surgery and members of the surgical divisional board.

The service had been commended for work in other areas including the introduction of a supernumerary consultant to provide direct support for trainees, and to help reduce delays for patients undergoing emergency surgery. Also noted as being forward thinking with robust escalation procedures and the presence of the airway technician role.

The service also carried out ongoing site marking audits in theatres and shared learning. Audit results were fed back at ward meetings and put on noticeboards.

Outcomes for patients were positive, consistent and met expectations, such as national standards. A consultant gynaecological surgeon told us they rated their service highly and achieved very good patient outcomes through progressing best practice. We read about the service’s improved patient outcomes. Consultant gynaecologists were present in elective obstetric surgery to provide any gynaecological surgery required. This avoided any unnecessary waits for expert surgeons. The service had twice daily board rounds to ensure all emergencies were reviewed by a consultant in a timely manner. This allowed all women the opportunity to ask questions they may have of the consultant post operatively. The service had a 24/7 consultant, senior registrar, junior, registrar and foundation year two junior doctor on call to meet the needs of the emergency service.

Managers and staff used audit results to improve patient outcomes. The service carried out monthly WHO deep dive audits and shared the results with all surgical division directorates. For example, in September 2019 staff audited the WHO “5 steps to safer surgery” using their three current audit methods for six lists across main theatres and the day procedure unit (DPU). The three audit methods were observational audit, WHO form completion compliance and electronic (ORSOS) tick box compliance. The results showed 100% of patients had a WHO completed and the average overall compliance across every patient combining all three audit methods was 98.6%. Managers cross referenced the audits to validate the results and provide quality assurance about their WHO checklist process.

Service leads listed improvements from these audits. These included the team re-introducing each verbally when they changed personnel, for example new surgeons to the list or a new DTL. Another improvement was full team engagement at the debrief after one debrief took place whilst the last patient was being woken up / extubated. They also worked to have a joint collaborative process after one theatre’s operating department practitioner (ODP) undertook the sign in without the anaesthetist.

We saw an audit of documentation completion in nurse-led dermatology clinics in May 2019. This assessed a sample of patient case notes to ensure staff’s compliance with trust policies. Results showed documentation reviewed was found to comply with record keeping policies. However, key concerns found infrequent minor improvements were required as staff did not always ensure patient details were recorded on every page, and not all entries were timed. The audit results and report were shared with the nursing team.

The service had devised and carried out an audit review of local safety standards for invasive procedures (locSSIPs) which were compliant with national safety standards for invasive procedures (natSSIPs). A set of natSSIPs were published by NHS England in September 2015 to
be modified for trust’s local use to produce locSSIPs. These are similar in principal to the World Health Organisation’s (WHO) surgical safety checklist and set out the key steps needed to deliver safe care for patients undergoing invasive procedures. The trust policy stated all clinical departments conducting designated invasive procedures must create and follow locSSIPs and that audits should be undertaken to ensure they were embedded in routine practice. For example, the service audited the locSSIP for flexible bronchoscopy in critical care in intubated patients to determine their adherence. A bronchoscopy is a procedure during which an examiner uses a viewing tube to evaluate a patient’s lung and airways including the voice box and vocal cord, trachea, and many branches of bronchi. The audit reviewed the data from 15 bronchoscopies excluding photo dynamic therapy (PDT) of which seven had documented the locSSIP. They found three patients did not have post procedure details completed.

The service had also audited the completion of their locSSIP for dermatology day case procedures, the Mohs’ micrographic surgery and minor operation procedures to determine compliance. Mohs is a microscopically controlled surgery used to treat common types of skin cancer. Of the 30 cases reviewed, 100% had a WHO checklist present in the notes which was relevant to the procedure undertaken. The WHO checklist was fully completed in 18 of the cases (60%). Checklist omissions occurred most frequently in clinic both numerically and as a percentage of the cases sampled. A summary of key concerns were checklists being signed before being fully completed in 60% of observed cases. This concern was also raised in the 2018/2019 observational audit. The other two concerns were partial or non-completion of the checklist’s sign out section (33%) and staff not documenting ‘specimen in pot’ being checked and confirmed (23%).

The service had quality improvement (QI) work underway. Staff used live platforms to undertake projects with matron sponsorship. We saw a list of life project summaries. For example, one project from October 2019 introduced an electronic self-competency assessment for using equipment within theatres and recovery. The service planned to give 90% of staff across the main theatres and DPU an updated account to complete this by October 2020.

The service planned to roll out and sustain improvement actions from pressure ulcer QI projects to be incorporated into trust policy. This included the use of an admission sticker, taping of nasogastric (NG) tubes and endorsing the use of a nasal oxygen delivery system with built-in ear protection. They also planned to produce a report within QI Life to map to monitor the QI projects related to essential care. This would help senior staff support QI projects and ensure they maintained progress, had the opportunity to share their findings and utilised learning to inform further improvements.

At the time of our inspection the service was carrying out a programme for pre-assessment of patients with dementia. Patient relatives could accompany them into the anaesthetic room. We spoke to one family who gave positive feedback. Service leads told us similar QI work was underway for patients with learning disabilities (LD).

We heard about a smartphone app designed by an anaesthetist to alert them and surgeons to any issues related to the blood results IT system. Any abnormal results could be cut and pasted in.

The service ensured it used cancer patient experience survey results and other cancer-related or cancer-specific patient surveys and feedback to improve quality and outcomes for people. The service’s colorectal patient experience improved as a result of the ‘straight to test’ pathway. Service leads compared percentage increases in lower GI data scores from the national cancer patient experience survey for questions for 2018 with 2017. For example, the number of patients who saw a GP once/twice before being told they had to go to hospital rose 13%. The number of patients told they could bring a family member or friend when they were first told they had cancer
rose 10%. The number of patients taking part in cancer research after discussions also rose 14%. The service used this data to compile an action plan led by the lead cancer nurse.

The trust’s national cancer patient experience survey analysis 2018 also showed 21% more skin cancer patients were definitely told about side effects that could affect them in the future and 18% more had any possible side effects explained to them in an understandable way.

Relative risk of readmission

Trust level

From June 2018 to May 2019, patients at the trust had a higher than expected risk of readmission for elective admissions when compared to the England average.

Urology, general surgery and plastic surgery patients at the trust had higher than expected risks of readmission for elective admissions when compared to the England average.

The service had a higher than expected risk of readmission for elective care than the England average. The service’s 30-day patient readmission rates one month in arrears did not meet the trust target of 10.45%. From September to November 2019 these did not fall below 11%. However, this did meet the national standard of 12%.

Elective Admissions – Trust Level

![Elective Admissions Graph]

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific trust based on count of activity

All patients at the trust had a slightly higher than expected risk of readmission for non-elective admissions when compared to the England average.

- General surgery patients at the trust had a similar to expected risk of readmission for non-elective admissions when compared to the England average.
- Urology patients at the trust had a lower than expected risk of readmission for non-elective admissions when compared to the England average.
- Plastic surgery patients at the trust had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

The service had a slightly higher than expected risk of readmission for non-elective care than the England average.

Non-Elective Admissions – Trust Level

![Non-Elective Admissions Graph]
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific trust based on count of activity

(Source: Hospital Episode Statistics - HES - Readmissions (01/06/2018 - 31/05/2019))

**Norfolk and Norwich University Hospital**

From June 2018 to May 2019, all patients at Norfolk and Norwich University Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.

Urology, general surgery and plastic surgery patients had higher than expected risks of readmission for elective admissions when compared to the England average.

The service had a higher than expected risk of readmission for elective care than the England average.

**Elective Admissions - Norfolk and Norwich University Hospital**

All patients at Norfolk and Norwich University Hospital had a slightly higher than expected risk of readmission for non-elective admissions when compared to the England average.

- General surgery patients had a similar to expected risk of readmission for non-elective admissions when compared to the England average.
- Urology patients had a lower than expected risk of readmission for non-elective admissions when compared to the England average.
- Plastic surgery patients had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

The service had a slightly higher than expected risk of readmission for non-elective care than the England average.

**Non-Elective Admissions - Norfolk and Norwich University Hospital**
Norfolk and Norwich University Hospitals NHS Foundation Trust

From June 2018 to May 2019, all patients at Norfolk and Norwich University Hospitals NHS Foundation Trust had a lower than expected risk of readmission for elective admissions when compared to the England average.

- Trauma and orthopaedics patients had a lower than expected risk of readmission for elective admissions when compared to the England average.
- Spinal surgery service patients had a higher than expected risk of readmission for elective admissions when compared to the England average.

The service had a lower than expected risk of readmission for elective care than the England average.

Elective Admissions - Norfolk and Norwich University Hospitals NHS Foundation Trust

The service had a slightly higher than expected risk of readmission for non-elective care than the England average.

(Source: Hospital Episode Statistics)

National Hip Fracture Database

Norfolk and Norwich University Hospital

The table below summarises Norfolk and Norwich University Hospital’s performance in the 2018 National Hip Fracture Database (NHFD). For five measures, the audit reports performance in quartiles. In this context, ‘similar’ means that the trust’s performance fell within the middle 50% of results nationally.
<table>
<thead>
<tr>
<th>Case ascertainment (Proportion of eligible cases included in the audit)</th>
<th>performance</th>
<th>to other trusts</th>
<th>standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>104.8%</td>
<td>Similar</td>
<td>Met</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Crude proportion of patients having surgery on the day or day after admission (It is important to avoid any unnecessary delays for people who are assessed as fit for surgery as delays in surgery are associated with negative outcomes for mortality and return to mobility)</th>
<th>performance</th>
<th>to other trusts</th>
<th>standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>76.3%</td>
<td>Similar</td>
<td>Did not meet</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Crude peri-operative medical assessment rate (NICE guidance specifically recommends the involvement and assessment by a Care of the Elderly doctor around the time of the operation to ensure the best outcome)</th>
<th>performance</th>
<th>to other trusts</th>
<th>standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>96.8%</td>
<td>Similar</td>
<td>Did not meet</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Crude proportion of patients documented as not developing a pressure ulcer (Careful assessment, documentation and preventative measures should be taken to reduce the risk of hospital-acquired pressure damage (grade 2 or above) during a patient’s admission); this measures an organisation’s ability to report ‘documented as no pressure ulcer’ for a patient</th>
<th>performance</th>
<th>to other trusts</th>
<th>standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>99.4%</td>
<td>Better</td>
<td>Did not meet</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Crude overall hospital length of stay (A longer overall length of stay may indicate that patients are not discharged or transferred sufficiently quickly; a too short length of stay may be indicative of a premature discharge and a risk of readmission)</th>
<th>performance</th>
<th>to other trusts</th>
<th>standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.0 days</td>
<td>Better</td>
<td>No current standard</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk-adjusted 30-day mortality rate (Adjusted scores take into account the differences in the case-mix of patients treated)</th>
<th>performance</th>
<th>to other trusts</th>
<th>standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1%</td>
<td>Within expected range</td>
<td>No current standard</td>
<td></td>
</tr>
</tbody>
</table>

(Source: National Hip Fracture Database)

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. We saw divisional and clinical leads annual reports and action plans with recommendations for national audit databases, for example hip fractures, emergency laparotomy and ophthalmology.

The service completed a situation, background, assessment, recommendation (SBAR) summary at their serious incident group (SIG) in response to an alert concerning data submitted to the NHFD. This data reported a mortality rate above the 95% control limit for 2018 data. The crude mortality data also suggested this was higher than the national average.

The service’s annual report was published in December 2019. This contained analysis of 30-day mortality for people aged 60 and over with fragility hip fractures. The report data covered patient admissions from 1 January to 31 December 2018. Many factors were considered when analysing the data which include crude mortality rates, case mix adjustments, age, sex, pre-fracture mobility and residence and fracture type.
Managers and staff investigated audit outliers, implemented local changes to improve care and monitored the improvement over time. The clinical lead for orthopaedic surgery, and the NHFD clinical lead for geriatric medicine confirmed the trust was not formally recorded as an ‘outlier’ as it does not meet this criteria. However, the data submitted caused an alert which required further investigation and an examination of data quality. The trust treated the NHFD alert notification seriously and was taking recommended actions in response. They planned an internal multidisciplinary team (MDT) structured judgement cohort review (SJR) for the 2018 patient admissions using case notes, to review and validate the data submitted. An SJR blends traditional, clinical-judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. The service contacted the British Orthopaedic Association to request an external review of their hip fracture service. They also gave updates to the NHFD on the above actions in October 2019.

**Bowel Cancer Audit**

The table below summarises Norfolk and Norwich University Hospitals NHS Foundation Trust’s performance in the 2018 National Bowel Cancer Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case ascertainment</td>
<td>95.4%</td>
<td>Good</td>
<td>Good is over 80%</td>
</tr>
<tr>
<td>Risk-adjusted post-operative length of stay &gt;5 days after major resection</td>
<td>69.0%</td>
<td>Worse than national aggregate</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk-adjusted 90-day post-operative mortality rate</td>
<td>3.9%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk-adjusted 2-year post-operative mortality rate</td>
<td>16.6%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk-adjusted 30-day unplanned readmission rate</td>
<td>7.4%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection</td>
<td>36.9%</td>
<td>Positive outlier</td>
<td>No current standard</td>
</tr>
</tbody>
</table>
(Source: National Bowel Cancer Audit)

The service completed national bowel cancer audits (NBoCAs) led by the colorectal surgeon and upper GI cancer lead. Audit concerns were to review and where relevant take action to improve participation, coding, data quality and timely reporting for the NBoCA. This was particularly true for case ascertainment, correct surgical and pathological data (particularly pre-treatment staging) and accurate coding and recording, for example, use of robotic surgery.

The audit found case ascertainment improvement was required with regards to data quality. The service had ongoing issues with their database. As a result, they needed a dedicated data entry clerk to support the accurate recording and submission of NBoCA data.

National Vascular Registry

The table below summarises Norfolk and Norwich University Hospitals NHS Foundation Trust’s performance in the 2018 National Vascular Registry.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Aortic Aneurysm Surgery</td>
<td>(Surgical procedure performed on an enlarged major blood vessel in the abdomen)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case ascertainment (Proportion of eligible cases included in the audit)</td>
<td>106.0%</td>
<td>Not applicable</td>
<td>Met</td>
</tr>
<tr>
<td>Risk-adjusted post-operative in-hospital mortality rate (Proportion of patients who die in hospital after having had an operation)</td>
<td>0.6%</td>
<td>Within the expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Carotid endarterectomy (Surgical procedure performed to reduce the risk of stroke; by correcting a narrowing in the main artery in the neck that supplies blood to the brain)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case ascertainment (Proportion of eligible cases included in the audit)</td>
<td>98.0%</td>
<td>Not applicable</td>
<td>Met</td>
</tr>
<tr>
<td>Crude median time from symptom to surgery (Average amount of time patients wait to have surgery after the onset of their symptoms)</td>
<td>8 days</td>
<td>Not applicable</td>
<td>Met</td>
</tr>
<tr>
<td>Risk adjusted 30 day mortality and stroke rate (Proportion of patients who die or have a stroke within 30 days of their operation)</td>
<td>1.8%</td>
<td>Within the expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Vascular Registry)

The service carried out national vascular registry (NVR) audits led by the consultant vascular surgeon. The audit’s successes found the trust was the seventh busiest aortic centre in the UK yet they had the seventh shortest average delay between assessment and surgery at 48 days. The trust’s average time from assessment to surgery for all infrarenal abdominal aortic aneurisms (AAAs) was within the eight week target set by the NHS AAA screening programme (NAAASP).
An AAA is an enlarged area in the lower part of the aorta, the major blood vessel that supplies blood to the body. The trust’s adjusted mortality rate was good. Their outcomes following repair of ruptured AAA was excellent and well below the national level. This demonstrated the high quality care provided by the service’s vascular surgery, interventional radiology and the critical care unit.

The service’s practice of a large proportion of open surgery was evidence-based and in line with the latest NICE guidelines. At the time of our inspection these were yet to be published. The large open surgery practice was also likely to have contributed to their better survival rate following ruptured AAA repair. The service were in the top quartile on documenting the percentage (100%) of patients with anaesthetic review.

However, the NVR audit found the trust were at the bottom quartile on documenting the percentage of patients with the date of anaesthetic assessment (74%), the percentage of patients undergoing pre-op CT/MR angiogram assessment (73%) and the percentage of patients discussed at MDT (74%). All elective AAA patients had a CT and were discussed at the trust’s vascular MDT and this should be recorded on the NVR. The audit also found the trust lacked IRU capacity. The trust also had long waiting times for routine and urgent angioplasty. At the time of our inspection routine had a waiting time of 18 months for an urgent angioplasty.

The trust took action to ensure all data points on the NVR were completed correctly. They also sought more staff to ensure all angioplasty cases were input into the NVR. Funding was made available to support staff recruitment to input this IRU data. However, at the time of our inspection this requirement was non-compulsory so inputting the data was not an incentive. The service’s new IRU suite had been approved and was scheduled to be built by late April 2020. The service ensured adequate HDU bed capacity to avoid cancellations. This also enabled them to continue achieving good results. They ensured adequate staff recruitment and retention on Denton ward to facilitate excellent patient care.

**National Oesophago-gastric Cancer Audit**
(Audit of the overall quality of care provided for patients with cancer of the oesophagus [the food pipe] and stomach)

The table below summarises Norfolk and Norwich University Hospitals NHS Foundation Trust’s performance in the 2018 National Oesophago-gastric Cancer Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust-level metrics (Measures of hospital performance in the treatment of oesophago-gastric (food pipe and stomach) cancer)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case ascertainment (Proportion of eligible cases included in the audit)</td>
<td>71% to 80%</td>
<td>Similar</td>
<td>No current standard</td>
</tr>
<tr>
<td>Age and sex adjusted proportion of patients diagnosed after an emergency admission (Being diagnosed with cancer in an emergency department is not a good sign. It is used as a proxy for late stage cancer and therefore poor rates of survival. The audit recommends that overall rates over 15% could warrant investigation)</td>
<td>18.2%</td>
<td>Similar</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk adjusted 90-day post-operative mortality rate (Proportion of patients who die within 90 days of</td>
<td>2.8%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>
their operation)

<table>
<thead>
<tr>
<th>Cancer Alliance level metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Measures of performance of the wider group of organisations involved in the delivery of care for patients with oesophago-gastric (food pipe and stomach) cancer; can be a marker of the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results. Contextual measure only.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Crude proportion of patients treated with curative intent in the Cancer Alliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Proportion of patients receiving treatment intended to cure their cancer)</td>
</tr>
<tr>
<td>37.7%</td>
</tr>
<tr>
<td>Similar</td>
</tr>
<tr>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Oesophago-Gastric Cancer Audit)

The service’s national oesophago-gastric cancer audit was led by the consultant surgeon and upper GI cancer lead. At the time of our inspection in December 2019 this report was about to be published. The audit was undergoing review by general surgeons. This would be discussed at the general surgery governance meeting on 10 March 2020.

National Emergency Laparotomy Audit

The table below summarises Norfolk and Norwich University Hospital’s performance in the 2016/17 National Emergency Laparotomy Audit (NELA). The audit reports on the extent to which key performance measures were met and grades performance as red (less than 50% of patients achieving the standard), amber (between 50% and 80% of patients achieving the standard) and green (more than 80% of patients achieved the standard).

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case ascertainment</td>
<td>94%</td>
<td>Green</td>
<td>Met</td>
</tr>
<tr>
<td>Crude proportion of cases with pre-operative documentation of risk of death</td>
<td>98%</td>
<td>Green</td>
<td>Met</td>
</tr>
<tr>
<td>Crude proportion of cases with access to theatres within clinically appropriate time frames</td>
<td>76%</td>
<td>Amber</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Crude proportion of high-risk cases (greater than or equal to 5% predicted mortality) with consultant surgeon and anaesthetist present in theatre</td>
<td>58%</td>
<td>Amber</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Crude proportion of highest-risk cases (greater than 10% predicted mortality) admitted to surgery post-operatively</td>
<td>70%</td>
<td>Amber</td>
<td>Did not meet</td>
</tr>
</tbody>
</table>
(10% or more) who are admitted to a Critical/Intensive Care ward after their operation

| Risk-adjusted 30-day mortality rate (Proportion of patients who die within 30 days of admission, adjusted for the case-mix of patients seen by the provider) | 10% | Within expected range | No current standard |

(Source: National Emergency Laparotomy Audit)

Improvement is checked and monitored. We saw the divisional reports received on the NELA from June 2019. The consultant anaesthetist (CA) and anaesthetic lead for emergency theatres noted the audit showed significant improvement in consultant presence for high risk cases with 90% for both consultants (up from 80% last quarter). HDU admission post-operatively had improved but was still below the required level to be RAG rated green (71% vs 85%).

The trust held a learning event in response which they advertised on their intranet, but this was poorly attended. The service was also developing a new set of intranet pages for the medical director (MD) with links to ensure they were using all avenues of communication.

At the time of our inspection the trust’s care of the elderly input was limited. The quarterly NELA report found only 11% of patients were seen by a care of the elderly specialist. This was below the national mean of 21%. Royal College of Surgeons (RCS) recommendations state all patients over 65 should have a frailty assessment. A medicine for the elderly consultant only reviewed patients over 80 years when referred for frailty. The trust had no service below this age.

Managers shared and made sure staff understood information from the audits. The trust carried out work to improvement engagement with NELA and ongoing data entry. The consultant anaesthetist was tasked with improving presence for high risk cases a year before our inspection. They had raised awareness, improved anaesthetic engagement, data entry and accuracy so this metric had improved to 88.8% in the last six months.

Previously NELA data entry was mainly performed retrospectively by a junior member of the surgical team. This relied on the ORSOS theatre record to find out who was present during surgery which could be very inaccurate. High-risk cases without an anaesthetic consultant were highlighted by the NELA surgical lead. The CA then contacted the anaesthetic trainee and consultant on call for that day to see who was present.

The anaesthetic consultant was often present in theatre but it was not recorded in ORSOS or on NELA. This shows the potential issues with retrospective data entry. In the last six months, contemporaneous data entry in theatre with anaesthetists starting the NELA entry has increased markedly with a subsequent improvement in data accuracy and recorded consultant presence.

The trust has recently joined the Eastern and Midlands Emergency Laparotomy Collaborative (ELC) which aimed to implement a six-point care bundle to improve outcomes. NELA data was taken and analysed to a greater depth than currently available on the NELA website. Collaborative working with other hospitals allowed benchmarking and sharing of best practice and solutions to common problems. Help with quality improvement and coaching was part of the CA’s two-year program. The bundle was closely aligned with the best practice tariff (BPT) in that two of the points of care are to have consultant presence and critical care admission for all high-risk patients. The BPT is a split tariff that pays at a higher rate for trusts that deliver care considered best practice; a lower rate will be paid to trusts failing to meet the requirements of the BPT. Other bundle measures included appropriate pre-operative resuscitation, sepsis assessment and treatment and timely surgery. The CA had just submitted the first set of data and was starting work on this project. Regular NELA (and now ELC) updates to anaesthetic and surgical governance meetings continued. Updates were also published in the theatre newsletter and on posters displayed in theatres.
In addition to the above, the trust had outlined seven specific measures related to RAG rated outcomes. These were:
- Estimated case ascertainment
- Consultant reported CT
- Risk documentation before surgery
- Arrival in theatre appropriate to urgency
- Consultant presence in theatre for higher mortality risk
- Admission to critical care for higher risk (5 and 10% predicted mortality)
- Post-operative assessment by care of the elderly

**National Ophthalmology Database Audit**

(Audit of patients undergoing cataract surgery)

The table below summarises Norfolk and Norwich University Hospital NHS Foundation Trust’s performance in the 2018 National Ophthalmology Database Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trust-level metrics</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Case ascertainment</strong></td>
<td>100.0%</td>
<td>N/A</td>
<td>No current standard</td>
</tr>
<tr>
<td>(Proportion of eligible cases included in the audit)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Risk-adjusted posterior capsule rupture rate</strong></td>
<td>0.8%</td>
<td>Better than expected</td>
<td>No current standard</td>
</tr>
<tr>
<td>(Posterior capsule rupture (PCR) is the index of complication of cataract surgery. PCR is the only potentially modifiable predictor of visual harm from surgery and is widely accepted by surgeons as a marker of surgical skill.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Risk adjusted visual acuity loss</strong></td>
<td>No data available</td>
<td>No data available</td>
<td>No current standard</td>
</tr>
<tr>
<td>(The most important outcome following cataract surgery is the clarity of vision)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: National Ophthalmology Database Audit)

The service carried out local safety standards for invasive procedures (locSSIP) audits in ophthalmology. We saw one for oculoplastic and lacrimal outpatient procedures. This used a sample of 30 cases over six months where patients attended ophthalmic outpatients for either the removal of tubes following lacrimal procedures, removal of sutures, the instillation of Botox to periocular tissue or the syringing & probing of lacrimal system. Results showed none of the 23 cases reviewed contained a copy of the LocSSIP Part B checklist, so compliance with this standard was demonstrated to be 0%. 11 cases (48%) met the standard for documenting the procedure, laterality and drugs administered. Further findings were patient consent was evidenced in only six cases; five where a formal consent form was present, and one where a WHO checklist stamp was used within the notes. The audit also found variable quality of entries in clinical notes such as the overall legibility of handwriting. The clinician signature was present in all cases, but it was not always clear who this was as no name was printed alongside their signature.
The service also carried out an ophthalmology audit of glaucoma laser treatment documentation to ensure patients had the necessary steps taken to ensure their safety and maintain good clinical practice. The audit sampled 90 cases over six months where patients had undergone treatment. In order to be compliant with documentation standards, each case was required to have evidence of signed consent, documentation relating to eye drops (SLT and PI only), and documentation of pre and post procedure checks. Results showed for the SLT procedure, only one of the 30 cases reviewed (3%) was identified to be fully compliant with all documentation standards. For PI and YAG procedures, the number of fully compliant cases was 0%. Documentation at each stage of the procedure was reviewed on an individual basis to identify areas for improvement. Consent forms were filed in the ophthalmology notes in 83 of the 90 cases reviewed. However, in most cases these were not fully completed.

**National Joint Registry**

(Audit of hip, knee, ankle, elbow and shoulder joint replacements)

The table below summarises Norfolk and Norwich University Hospital’s performance in the 2018 National Joint Registry.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust-level: Case ascertainment (hips, knees, ankles and elbows)</td>
<td>100.0%</td>
<td>Better</td>
<td>Met</td>
</tr>
<tr>
<td>(Proportion of eligible cases within the trust that were submitted to the audit)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of patients consented to have personal details included (hips, knees, ankles and elbows)</td>
<td>98.9%</td>
<td>Better</td>
<td>Did not meet</td>
</tr>
<tr>
<td>(Patient details help ‘track and trace’ prosthetics that are implanted. It is regarded as best practice to gain consent from a patient to facilitate entering their patient details on to the register)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital level: Hips Risk-adjusted 5 year revision ratio (for hips excluding tumours and neck of femur fracture)</td>
<td>1.0</td>
<td>Within expected range</td>
<td>Met</td>
</tr>
<tr>
<td>(Proportion of patients who need their hip replacement ‘re-doing’)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk adjusted 90-day post-operative mortality ratio (for hips excluding tumours and neck of femur fracture)</td>
<td>1.0</td>
<td>Within expected range</td>
<td>Met</td>
</tr>
<tr>
<td>(Proportion of patients who die within 90 days of their operation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital level: Knees Risk-adjusted 5 year revision ratio (for knees excluding tumours)</td>
<td>0.6</td>
<td>Within expected range</td>
<td>Met</td>
</tr>
<tr>
<td>(Proportion of patients who need their knee replacement ‘re-doing’)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk adjusted 90-day post-operative mortality ratio (for knees excluding tumours)</td>
<td>1.1</td>
<td>Within expected range</td>
<td>Did not meet</td>
</tr>
<tr>
<td>(Proportion of patients who die within 90 days of their operation)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The service’s national joint registry was led by the consultant orthopaedic surgeon. The audit found there was no significant poor outlier status for any surgeon and no actions were identified.

### National Prostate Cancer Audit

The table below summarises Norfolk and Norwich University Hospital NHS Foundation Trust’s performance in the 2018 National Prostate Cancer Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Men with complete information to determine disease status</strong></td>
<td>97.2%</td>
<td>N/A</td>
<td>Did not meet</td>
</tr>
<tr>
<td>(This is a classification that describes how advanced the cancer is and includes the size of the tumour, the involvement of lymph nodes and whether the cancer has spread to different part of the body)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage of patients who had an emergency readmission within 90 days of radical prostatectomy</strong></td>
<td>16.4%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>(A radical prostatectomy involves the surgical removal of the whole prostate and the cancer cells within it; emergency readmission may reflect that patients experienced a complication related to the surgery after discharge from hospital)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage of patients experiencing a severe urinary complication requiring intervention following radical prostatectomy</strong></td>
<td>9.3%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>(Complications following surgery may reflect the quality of surgical care)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage of patients experiencing a severe gastrointestinal complication requiring an intervention following external beam radiotherapy</strong></td>
<td>22.9%</td>
<td>Negative outlier</td>
<td>No current standard</td>
</tr>
<tr>
<td>(External beam radiotherapy uses high-energy beams to destroy cancer cells)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: National Joint Registry)

(Source: National Prostate Cancer Audit)

The service carried out national prostate cancer audits led by the consultant urologist. The latest audit found compliance with nine out of the ten recommendations for prostate cancer teams (local and specialist MDTs) within NHS trusts/health boards.
However, the audit raised concerns around non-compliance with recommendation number five: 'Investigate why men with high-risk/locally advanced disease are not considered for radical treatment (R5).’ At the time of our inspection the trust did not undertake enough staging investigations for patients with locally advanced disease. Any trust patient with a prostate specific antigen (PSA) above 30 did not qualify for an MRI which was essential if the service had to offer radical treatment such as surgery. A male patient’s PSA or blood level is often a good indicator of how effective treatment is or has been. This was the service’s biggest constraint. The service’s PET capacity was also limited and was not enough if they needed to consider all locally advanced cases for radical treatment.

The service took action as a result of the audit which they presented at the urology clinical governance meeting on the 16 January 2020. The trust reviewed the resources they provided to investigate if further recommendations were required. However, the trust reviewed all the high risk cases closely and ensured they were considered for radical treatment at multi-disciplinary team (MDT) meetings.

**Patient Reported Outcome Measures**

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left. These changes are measured in a number of different ways, descriptions of some of the indicators presented are below.

Visual analogue scale (EQ VAS) asks patients to mark their health status on the day of the interview on a vertical scale. The bottom rate (0) corresponds to “the worst health you can imagine”, and the highest rate (100) corresponds to “the best health you can imagine”.

The EQ-5D-5L questionnaire has two parts. Five domain questions ask about specific issues, namely: mobility, self-care, usual activities, pain or discomfort, anxiety or depression. The EQ-5D-5L uses five levels of responsiveness to measure problems. The range is: no problem to disabling/extreme.

The Oxford Hip Score (OHS) is a patient self-completion report on outcomes of hip operations containing 12 questions about activities of daily living. A simple scoring and summing system provides an overall scale for assessing the outcome of hip interventions.
In 2016/17 performance on groin hernias was better than the England average for both the EQ VAS and the EQ-5D index indicators.

For hip replacements, performance was similar to the England average for the EQ VAS, EQ-5D index and Oxford hip score indicators.

For knee replacements performance was better than the England average on the EQ VAS and similar for the EQ-5D index and Oxford Knee Score.

For varicose veins, performance was better than the England average on the Aberdeen Varicose Vein Questionnaire and EQ-5D index, but worse on the EQ VAS scale.

(Source: NHS Digital)

The service was accredited by (give the scheme name).

We saw four of the service’s wards compiled quality assurance audit accreditation forms from October 2019.

Competent staff

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

Staff were qualified and had the right skills and knowledge to meet the needs of patients. However, staff were not always experienced. Staff told us they felt they had the necessary skills and knowledge to carry out their roles and responsibilities effectively. The service carried out yearly updates of staff competencies. For example, the service planned competencies for adult nurses looking after children by January 2020.

All qualified staff in the day procedure unit (DPU) recovery were ILS and PILS trained. New staff had to complete competencies before they could work in recovery. However, nursing staff raised concerns about their staff not feeling they had the skill sets to meet the needs of all their patients. Staff told us there was an expectation they could manage all patients when the exclusion criteria was often ignored. For example, nursing staff were untrained to care for patients with central lines, epidurals or bladder irrigation. Central lines are sometimes called skin-tunnelled central venous catheters. They are used to give chemotherapy treatment or other drugs. A central line can stay in until a patient’s chemotherapy is finished.
The clinical development facilitator (CDF) organised information governance (IG) and mandatory training course days according to need. They told us student nurses and operating department practitioners (ODPs) helped them decide which human factors training issues to focus on. At the time of our inspection 244 staff had completed human factors scenario training. This had started in January 2019 and ran on all governance days.

The CDF ensured staff’s knowledge of policy was updated through scenarios such as table top exercises and simulation training was also being trialled. On the first day of our inspection we heard about a team building exercise related to improving staff communication in theatres.

Training was provided according to clinical staff need and service demand. For example, the service carried out more ankle replacement day surgery so more training had been rolled out. A clinical educator told us about know your staff HR training for band 6s and 7s.

Team meetings were held monthly and minuted. Agenda included positive feedback, compliments and complaints, and learning from incidents was shared. However, on Coltishall ward team meetings were only held every two or three months. These were minuted and topics covered included staffing issues, feedback and developments within surgery.

The service ensured all staff only carried out surgery they were skilled, competent and experienced to perform. For example, service leads highlighted the scope of practice for scrub practitioners and surgical first assistants in the monthly newsletter for theatres and recovery staff. A list of their roles and responsibilities was shown below. They were asked to feel empowered to decline if they were being asked to practice outside their scope of practice. They were reminded to escalate to their team leader or red spot if they were unable to protect both themselves as practitioners and the patient.

The service made arrangements for supporting and managing staff to deliver effective care and treatment which included mentoring. The practice education team had started a mentor forum in June 2019 on every governance day. All mentors were welcome to improve their standard of assessment by problem solving, querying paperwork, learning from other’s experiences, reflecting and raising standards of practice and change for nurses.

Divisional teams had worked to a series of standard operating policies (SOPs) since 2018. These SOPs structured communication and coordination within and between each theatre, and between their departments. SOPs also provided guidance on individual staff roles and responsibilities, communication lines and the structure and timeliness of check in meetings and review points. Theatre staff roles were easily identifiable by their use of coloured hats.

One staff nurse on Edgefield ward told us staff didn’t have the appropriate or well-developed skills to care for sick urology patients. In DPU ward areas training and development was compromised due to insufficient staffing numbers to provide clinical care.

The service had link nurses to coordinate the needs of patients with learning disabilities (LD), mental capacity act (MCA) issues, dementia and paediatrics. However, staff we spoke with were not always aware who they were.

At the time of our inspection service leads were expanding their provision of practitioners. For example, advanced critical care practitioners (ACCPs) in training aimed to be part of the junior doctor rota by February 2020. Surgical care practitioner and advanced nurse practitioner roles were also being recruited to in general surgery and urology along with a nurse registrar in dermatology, physician assistants and surgical first assistants in theatres. The service had undertaken trainee nursing associates (TNAs). These roles were available across a mix of theatres, wards and outpatients which helped the service ‘grow their own’ staff in-house. The first cohort of 11 TNAs finished in September 2019.
Managers gave all new staff a full induction tailored to their role before they started work. All new staff received a trust induction before they started work in their appointed role, and managers tailored a local induction to the clinical area. Newly qualified nurses had a named preceptor who completed the staff member’s competency sign off. One ward manager showed us the induction packs they gave to student nurses and new staff. Bank staff were ‘buddied’ with another member of the team if it was their first shift on the ward.

**Appraisal rates**

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff had annual appraisals which they found useful. We saw up to date and productive Edgefield urology ward appraisals were at 83.8% at the time of our inspection. Service leads had plans in place to continue to improve these.

One Gateley ward staff member told us appraisals enabled them to have the training they wanted. Some appraisals had led to developing areas of interest. For example, a health care assistant (HCA) on the Docking ward had started educating other staff in pressure area care. One Band 5 nursing staff on secondment told us they were encouraged to pursue a band 6 permanent role.

However, the service’s non-medical appraisal rates from September to November 2019 were below both the national and trust target of 85%. These had reduced from 79% to 75.2%.

The trust informed us some of their anaesthetics staff had merged workloads with the critical care team. Therefore, the appraisal analysis below for medical staff includes some staff working across surgery and critical care.

**Trust level**

From August 2018 to September 2019, 83.5% of required staff in surgery (and critical care) at trust level received an appraisal compared to the trust target of 85%.

The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>August 2018 to July 2019</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>85%</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>210</td>
<td>223</td>
<td>94.2%</td>
<td>85%</td>
</tr>
<tr>
<td>Healthcare scientists</td>
<td>15</td>
<td>16</td>
<td>93.8%</td>
<td>85%</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>393</td>
<td>448</td>
<td>87.7%</td>
<td>85%</td>
</tr>
<tr>
<td>Additional professional scientific and technical staff</td>
<td>125</td>
<td>145</td>
<td>86.2%</td>
<td>85%</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>162</td>
<td>199</td>
<td>81.4%</td>
<td>85%</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>179</td>
<td>250</td>
<td>71.6%</td>
<td>85%</td>
</tr>
<tr>
<td>Estates and ancillary</td>
<td>60</td>
<td>90</td>
<td>66.7%</td>
<td>85%</td>
</tr>
<tr>
<td>Total</td>
<td>1,149</td>
<td>1,376</td>
<td>83.5%</td>
<td>85%</td>
</tr>
</tbody>
</table>

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

Managers supported nursing and medical staff to develop through regular, constructive clinical
supervision of their work. Theatre operating staff had to complete competencies for each surgical speciality before they could undertake an operating list without supervision. The theatre manager had a staff competencies and training completion spreadsheet. Recovery staff had comprehensive recovery competencies which included airway and pain management. Theatre rotas were co-ordinated to ensure staff had the right competencies for the planned theatre lists.

The clinical educators supported the learning and development needs of staff. A clinical educator told us the service had in-house trainers for all core MT disciplines and staff’s personal development plans (PDPs) were flagged wherever they were behind. They said with their support the day procedure unit (DPU) staff were almost achieving 90% MT compliance. The service had a DPU governance programme which included mandatory updates.

The service’s Edgefield ward planned to have a clinical educator who would work alongside the new urology nursing staff who had limited experience to ensure support and build urological knowledge. They could also develop new ideas and ensure mandatory training compliance in clinical aspects. At the time of our inspection the service were not currently able to fund this but the UNP were still working closely with ward nurses to set up more education sessions. Edgefield’s extra band six was an experienced urology nurse. This meant the ward would have a senior urology nurse on every shift to provide support.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend. Managers used different methods of communication with staff. Ward staff were encouraged to attend ward meetings where possible. Ward managers used staff notice boards, closed social media groups, email and newsletters to communicate key messages with staff.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. For example, we saw a chief executive oversight (CEO) assurance panel action plan for the Edgefield ward in response to increased concerns around sub-optimal care incidents. Managers drew up templates for the implication of three-hour study days for them to use alongside probationary paperwork. This would be implemented every three months and include time spent with the urology on-call team, bed manager, and attending operational meetings.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers and staff we spoke with told us they were encouraged to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. We saw dementia links study day posters which gave staff the opportunity to update their knowledge and learn new skills related to their role.

Managers recruited, trained and supported volunteers to support patients in the service. The trust invested in volunteering and had around 720 experienced volunteers. The trust had five volunteer coordinators with advanced training. For example, the service used butterfly volunteers who provided company and companionship to surgical patients and their families. Staff could make a referral to a coordinator. One of the trust’s volunteers won a staff award in November 2019.

**Multidisciplinary working**

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Multidisciplinary (MDT) meetings were held twice daily. These were attended by nurses, physiotherapists, occupational therapists and a discharge co-ordinator. Other staff were invited if required depending on the nature of the patients.

We attended an MDT meeting on the elective orthopaedic ward. Although no medical staff attended there was an acting matron, deputy sister, rotational band 5 nurse, senior discharge coordinator, assistant practitioner and three allied health professionals including a senior physiotherapist.

The physical, mental and psychological health needs of all ward patients were discussed. This included patient’s conditions and preferences, any pain management issues, how they were progressing with physiotherapy and any equipment needs. In relevant cases staff also considered any family dynamics or carer responsibilities which had an impact. Staff requested home and community care packages early as we heard these were often delayed. Potential discharge dates and transport requirements were also covered with tablets to take home (TTOs) and paperwork prepared in advance.

Staff considered the patient’s personal needs, preferences and what was normal for them in terms of mobility or mental capacity. They were not pressured to discharge patients if they felt this was unsafe. For example, the MDT reviewed one patient who now had good mobility but staff were not ready to discharge them as they had dislocated their hip 20 times, had a complex medical history and anxiety issues.

The service had begun a quality improvement (QI) life project in December 2019 to improve the quality of tissue viability and Waterlow score documentation. The Waterlow score or scale gives an estimated risk for the development of patient pressure sores. They planned to do this by educating staff about Waterlow scores and how they affected patient requirements. This helped staff determine whether the patient required more resources such as a pressure relieving air mattress.

Seven-day services

Key services were available seven days a week to support timely patient care.

The day procedure unit (DPU) escalation area opened 7am to 10pm Monday to Friday, 7am to 8pm Saturdays and was closed on Sundays. The discharge lounge (Aylsham suite) was open 7am to 7.30pm six days a week and 7am to 5pm on Sundays. The pharmacy had recently extended their Sunday opening hours. Pharmacy support was available to surgical specialties including orthopaedics, ophthalmology and pre-operative assessment.

However, the pharmacy service offered a limited ward service to trauma and orthopaedics from 9-1 on weekends and 9-4 on bank holidays.

Consultants led daily ward rounds on all wards, including weekends. Patients are reviewed by consultants depending on the care pathway. Surgery services provided consultant led care 24 hours a day, seven days a week. Consultants completed ward rounds seven days a week and were available on-call out of hours.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Staff had access to mental health support for their patients 24 hours a day, seven days a week. Staff could contact a mental health
liaison service from a local trust as part of the Norfolk and Waveney sustainability transformation partnership (STP). Staff could also contact the crisis response team for support and advice.

The service offered 24/7 gynaecological emergency service referrals. These were taken from midwives, GPs, primary care, ambulance service, ED and internal open access. This improved women’s experience by avoiding unnecessary waits in ED and provided a dignified, private environment to meet their needs. All gynaecological nurse-led services had 24/7 access to a gynae consultant for advice and support as required.

The service had access to all key diagnostic services such as diagnostic imaging and laboratory services seven days a week. The service supported clinical decision making within set timeframes. For example, diagnostic staff completed all critical imaging and reporting for patients within an hour, all urgent imaging and reporting within 12 hours and all non-urgent within 24 hours. However, the service struggled to provide formal emergency interventional radiology services 24/7 to patients where appropriate.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on the wards/units. We saw enhanced recovery pathways for hip and knee patients on the Cringleford ward.

Ward staff told us they knew how to access a substance misuse specialist nurse. They reported timely and appropriate referrals from the staffing team on Docking Ward.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Since our last inspection the service had made quality improvements in staff’s knowledge and implementation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Four staff we spoke to were able to clearly articulate their awareness and understanding of MCA and DoLS and gave examples how to identify and address concerns around patient capacity and consent.

The service had devised resources such as credit card sized MCA assessment hints and patient labels to remind staff to complete assessments and improve organisational wide learning. We saw MCA prompts in the service’s January 2019 monthly newsletter for theatres and recovery staff.

Staff understanding of MCA was mixed on previous inspections. This was raised as a warning notice on our last inspection.

However, the service struggled to evidence this good practice.

A paediatric nurse told us they completed MCA screening at pre-assessment face to face.
Staff gained consent from patients for their care and treatment in line with legislation and guidance. Consent was gained from patients before any treatment was given. In the records we reviewed where patients had a procedure, all contained valid consent signed by the patient.

When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions. We saw staff had completed MCA forms with best interest decision factors after meeting with or contacting the patient’s next of kin or relatives.

Staff made sure patients consented to treatment based on all the information available. Patients told us they had been given enough information on which to make a judgement about whether to have treatment and were told the risks and complications of the procedure. We observed numerous occasions when verbal consent was requested for care activities and interventions such as taking blood pressure readings.

Patient consent was gained ahead of their procedure. This was either completed before admission and consent confirmed again before the procedure or shortly before the procedure in the case of minor procedures. We observed patients being given time to consider the procedure and ask any questions they had. Four consent forms we saw were fully completed and signed with benefits and risks of the procedure detailed.

Staff clearly recorded consent in the patients’ records. We reviewed the records of two patients subject to DoLS during our inspection. We found the appropriate records, decision and authorisation to be in place. We spoke to the trust’s DoLS advisor who carried out daily MCA assessments and adherence to protocol on the wards. They ensured staff completed these correctly, for example with patients who had fractured neck of femurs (NoF).

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. DPU staff we asked could describe Gillick competence (which is concerned with a child’s capacity to give consent) and how they would apply it. They knew where to access resources to support them in the decision making.

Mental Capacity Act and Deprivation of Liberty training completion

Nursing staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). DoLS mandatory training was available online and face to face for all staff. Not all staff we spoke to had completed MCA training, but they understood it related to a person’s ability to make a specific decision. Staff would raise any concerns they had with the nurse in charge. If staff felt a patient lacked capacity, they would involve a doctor to complete a capacity assessment. This would be recorded in the patient’s notes.

Nurses could carry out assessments if they felt confident. There was a flow chart in place to help which included steps to follow. Staff could contact colleagues or the safeguarding team for advice.

Clinical staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards but did not always keep this up to date. Of the eligible medical staff in surgery (and critical care) 55 had not completed the MCA level two and DoLS training modules.

The trust set a target of 90% for completion of mental capacity act (MCA) and deprivation of liberty safeguards (DoLS) training.

Trust level
A breakdown of compliance for MCA/DoLS training modules from August 2018 to July 2019 at trust level for qualified nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
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<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Mental Capacity Act level 2</td>
<td>443</td>
<td>466</td>
<td>95.1%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Deprivation of liberty safeguards</td>
<td>443</td>
<td>466</td>
<td>95.1%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In surgery the target was met for both MCA/DoLS training modules for which qualified nursing staff were eligible.

Please note that the trust informed us that some of their anaesthetics medical staff have merged workloads with the critical care team. Therefore, the analysis below includes some medical staff working across surgery and critical care.

A breakdown of compliance for MCA/DoLS training modules from August 2018 to July 2019 at trust level for medical staff in surgery (and critical care) is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Mental Capacity Act level 2</td>
<td>281</td>
<td>336</td>
<td>83.6%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Deprivation of liberty safeguards</td>
<td>279</td>
<td>334</td>
<td>83.5%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery (and critical care) the target was not met for either MCA/DoLS training modules for which medical staff were eligible.

**Norfolk and Norwich University Hospital**

A breakdown of compliance for MCA/DoLS training modules from August 2018 to July 2019 for qualified nursing staff in surgery at Norfolk and Norwich University Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
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<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Mental Capacity Act level 2</td>
<td>427</td>
<td>450</td>
<td>94.9%</td>
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<td>Yes</td>
</tr>
<tr>
<td>Deprivation of liberty safeguards</td>
<td>427</td>
<td>450</td>
<td>94.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In surgery the target was met for both MCA/DoLS training modules for which qualified nursing staff at Norfolk and Norwich University Hospital were eligible.

Please note that the trust informed us that some of their anaesthetics medical staff have merged workloads with the critical care team. Therefore, the analysis below includes some medical staff working across surgery and critical care.

A breakdown of compliance for MCA/DoLS training modules from August 2018 to July 2019 for medical staff in surgery (and critical care) at Norfolk and Norwich University Hospital is shown below:
In surgery (and critical care) the target was met for either MCA/DoLS training modules for which medical staff at Norfolk and Norwich University Hospital were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice (AMSAT). We saw two clearly completed and cross-signed MCA forms where staff had used a multi-disciplinary team (MDT) working approach. The reasons given and notes detailing patient capacity were satisfactory. However, we could not confirm if these decisions were discussed with patient relatives or carers.

The service had done a lot of work around MCA since our last inspection. The service worked collaboratively with the mental health (MH) team to meet the needs of surgical patients with acute MH needs. Since our inspection, the clinical leader for inpatient recovery was working with the MCA/DoLS lead on a campaign to embed departmental understanding of the MCA and DoLS in the theatre environment. MCA staff engagement had also been carried out at the theatres senior staff meeting, recovery senior staff meeting and recovery weekly meeting. Staff views were sought through presentation at a governance update meeting in February 2020. The service had set up a cross-departmental project team and developed scenarios to support the project. Delegated group members drafted an introductory poster/storyboard which went on display ahead of the trust’s ongoing MCA poster campaign.

Managers monitored the use of Deprivation of Liberty Safeguards (DoLS) and made sure staff knew how to complete them. We checked two DoLS authorisations. Standard requests were completed, signed and dated by staff to supplement urgent authorisations after the seven day expiration. The trust sent us statutory notifications on deaths and serious injuries of service users whilst on the service’s wards and theatres.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff told us they knew how to contact the mental health liaison team and the MCA matron for support.

The service’s LD nurse could assist staff with mental capacity assessments, allowing the individual to be assisted in understanding their care and support needs to avoid assumptions of a person’s capacity/level of understanding. They could also involve family/carers/others who were important in the person’s life. They challenged others to ensure best interests were the focus of all decision-making processes.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. Service leads told us MDT working around mental capacity assessment (MCA) scenarios and issues was more helpful than didactic training from above. The service used an IT icon system to record and track any safeguarding, capacity and consent patient details. All staff could access this on their PC desktops and were supported by a named MCA matron.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. We reviewed a DoLS form granting urgent authorisation for a type one diabetic patient with...
Alzheimer’s disease who was in the care of surgeons awaiting a care plan to resolve and treat their ischemic foot. All relevant sections had been fully completed. However, the form gave no information about interested persons or others as staff recorded no appropriate contacts with which they could consult about the patient’s best interests.
Is the service caring?

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw staff using privacy curtains on wards.

Patients said staff treated them well and with kindness. Patients we spoke to described staff as friendly, polite and helpful. They said everything about their care and treatment was explained well, they were kept informed and able to ask questions.

Patients told us it could be noisy at night, but this was due to other patients rather than staff. They said staff helped to settle the patient. One patient on the docking ward told us she was in a lot of pain during the night. A staff member sat with her after administering morphine until she felt better.

Staff did not follow policy to keep patient care and treatment confidential. Staff closed privacy curtains when treating or talking to patients about personal care so they could not be overheard. However, we saw lockable patient notes trolleys were left open and accessible across all wards.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. We read thank you cards on Coltishall ward. One post-operative breast cancer patient thanked staff for being so caring, helping her prepare and feel valued. Another patient’s partner thanked staff for helping them die peacefully with dignity and respect.

Patients were assigned a specific nurse and HCA so staff would be familiar to them. However, the staff-named board in the side room of one patient we spoke to was two days old.

Staff were able to request chaplaincy support for patients or patients were able to contact chaplaincy independently. One patient said they were told about the chaplaincy and were made aware of support and how to access it.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. Patients on the docking ward told us staff always pulled the curtain around and tried to speak to them discreetly.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Some patients who had surgery as part of cancer treatment also accessed services at the Colney Centre where they had access to support services. Whilst there were no counselling services
provided directly, staff could refer patients for counselling if it was felt to be beneficial.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. All patients we spoke with told us of the support they received from staff. One relative told us that staff offered emotional support to them during a difficult time.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Patients, relatives and their significant others told us that they were kept informed of their treatment and were involved with the plans for their care. All told us they had been supported to make decisions about their care. Records we checked showed good communication with patients about their options about the progress of their care.

We spoke with one relative who told us the consultant had called them daily at their request to update them on their spouse’s condition as they were unable to visit frequently. They told us they felt fully informed and had been involved by teleconference for discharge planning arrangements.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We observed staff explain procedures to patients and involve them in their care by allowing them to ask and answering any questions. One patient told us that they had been given all the information they had needed to allow them to manage their care after discharge.

Patients and their families could not always give feedback on the service and their treatment but staff supported them to do this. Ward staff told us they could help patients and relatives complete feedback forms before discharge. However, we did not see any friends and family test (FFT) surveys on reception desks or other ways patients could leave feedback.

A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey. The service’s Edgefield ward achieved an FFT score of 96% of patient’s friends and families who would recommend the services for October 2019. We saw a lack of day procedure unit (DPU) service provision negatively affected friends and family test results and patient experience.

Patients gave positive feedback about the service. Staff could give examples of how they used patient feedback to improve the quality of care they provided.

Friends and Family test performance

The Friends and Family Test response rate for surgery at Norfolk and Norwich University Hospitals NHS Foundation Trust was 6.7% which was lower than the England average of 26.6% from October 2018 to September 2019. A breakdown of response rate by site can be viewed below.

Friends and family test response rate at Norfolk and Norwich University Hospitals NHS Foundation Trust, by ward/team
### Table: Evidence Appendix

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<thead>
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<tbody>
<tr>
<td>Surgical day unit</td>
<td>3,021</td>
<td>4%</td>
<td>96%</td>
<td>99%</td>
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<tr>
<td>Coltishall Ward</td>
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<td>99%</td>
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<tr>
<td>Docking Ward</td>
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<td>29%</td>
<td>96%</td>
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<td>92%</td>
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<td>96%</td>
<td>94%</td>
<td>96%</td>
<td>88%</td>
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<tr>
<td>Gatesley Ward</td>
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<td>95%</td>
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<td>100%</td>
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<tr>
<td>Easton Ward</td>
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<td>Dilham Ward</td>
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<tr>
<td>Cringleford Ward</td>
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<tr>
<td>Denton Ward</td>
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<td>96%</td>
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</tbody>
</table>

**Key**

- Highest score to lowest score
- 100% 97% 81%

1. The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above), as well as wards where there were less than 100 responses in total over the 12-month period.

2. Sorted by total response.

3. The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)
Is the service responsive?

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the changing needs of the local population. The service responded to demand by creating nurse consultant posts in gastroenterology and respiratory to lead on cancer pathways. This included a lung cancer post which will be developmental over a three-year period, commencing at medical registrar level and leading to a nurse consultant post.

The service had carried out a life QI project in January 2019 to improve compliance with the mouthcare policy patient comfort and oral health of intubated and ventilated patients over a three month period.

The service had carried out a life quality improvement (QI) project in February 2019 to implement the role of an associate cancer clinical nurse specialist (CNS) and standardise their competency levels. The service also carried out a life QI project in May 2019 to offer patients choice over where they had intravenous (IV) iron therapy pre-operatively. This met the needs of patients living south of Norwich.

Service leads had also responded to demand for interventional radiology (IR) services which had risen year on year. For example, the service organised Saturday voluntary lists where these wards could be staffed. The service prioritised cases based on clinical need. One “long day” was introduced, with two more long days commencing from June 2014 to create more capacity. If longer days did not yield enough capacity to meet rising demands, the service recommended taking further action by submitting a business case for a second IRU suite. The service had invested in nursing and radiographer posts to support long days. At the time of our inspection their training was underway. These measures helped the IR department keep pace with current demand.

At the time of our inspection the day procedure unit (DPU) senior staff had issued an escalation update. This was the results of information gathered from various incidents, discussions, meetings and staff feedback. The DPU had an ongoing recruitment programme including a band 6 secondment role. All bank staff had been sent an email to build a dedicated team for the two lion and golden escalation bays open until April 2020.

The service created 17 medical beds on Gissing ward which opened before the DPU from 9 December when wards were under pressure. The service was considering stopping booking day case patients onto golden ward. Discussions were taking place to proactively plan not to book children onto the lion ward. The service had also considered and rejected a plan to use the Vanguard unit as a standalone children’s area. Senior staff had worked with pharmacy to explore increasing the range of drugs stocked on the two escalation bays.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. For example, the DPU had all single sex bays and changing rooms.

Facilities and premises were appropriate for the services being delivered. The service planned to open a new four procedure room interventional radiology unit (IRU) in April 2020. At the time of our inspection we saw this being built.
The service had systems to help care for patients in need of additional support or specialist intervention. For example, the service held a lithotripsy clinic 1.5 to 2.5 days a week to carry out biopsies. Lithotripsy is a medical procedure involving the physical destruction of hardened masses like kidney stones, bezoars and gallstones. They saw five to ten patients a day and were expanding the service to be more inclusive and rolling it out to neighbouring trust hospitals.

**Meeting people’s individual needs**

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. (AMSAT) The service had a learning disability (LD) nurse team comprising a liaison nurse lead, a children and young people’s liaison nurse and an adult liaison nurse. We saw their contact details and photos were advertised in October 2019’s monthly newsletter to all theatres and recovery staff. In the same newsletter staff were reminded how to care for LD patients.

The service’s LD nurse worked in partnership with the LD liaison team and those involved with care and support. They worked as an advocate to help staff assess, plan, implement and evaluate individualised care for LD patients by seeing the person and their likes, dislikes, wishes, personality and strengths first. The LD nurse identified levels of support to ensure patient safety, recognised vulnerabilities, could respond to people experiencing distress or complex behaviours and promoted the rights of people with disabilities.

We heard about a specific weekly list for learning disabilities (LD) patients who had access to dental treatment in the community. The service had a quality improvement (QI) project underway to build training resources for LD patients.

At the time of our inspection the service had completed a dementia audit. This showed 100% of dementia patients had been issued with sensory bands, a ‘this is me’ booklet, had a flower placed above their bed and been flagged on the patient alert system (PAS).

Wards were designed to meet the needs of patients living with dementia. The service had made quality improvements to create a more beneficial environment for patients with dementia. Staff placed a blue flower above the bed of patients with dementia, but there were no dementia friendly areas. Volunteers came and sat with patients.

Staff supported patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports. The service used ‘this is me’ booklets for dementia patients and hospital healthcare passports for learning disabilities (LD) patients. LD patients were given a rapid risk assessment and emergency admission plan. Staff could also access assessments to support adults with LD within theatre and laminated copies available to view on their LD board. They were encouraged to seek recommendations from either the LD liaison or theatre nurses.

Service leads prompted staff to identify if it was possible for patients with LD to be listed first, allow them more time, keep staffing to a minimum in the anaesthetic room, try to enable continuity of patient care, recognise key indicators such as their likes and dislikes and provide individualised information to recovery.

Staff understood and applied the policy on meeting the information and communication needs of
patients with a disability or sensory loss. Day procedure unit (DPU) staff could assist wheelchair or stretcher bound patients by adding an airflow mattress to their inpatient bed ahead of recovery as these were more comfortable than a foam mattress. Hoists and bariatric equipment for patients was ordered after being highlighted at their pre-operative meeting.

The service could offer child patients age appropriate information books on what to expect during their procedure developed by one of the nurses. Staff told us about a ‘little journey’ app which children’s family or carers could download. This was a virtual reality (VR) walk through with a visor to help children familiarise themselves with the procedure.

The service had information leaflets available in languages spoken by the patients and local community. Gateley ward had made a leaflet for visitors of the ward’s visiting hours and several polite requests.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. Staff could request interpreters for patients through language line. Patients could request chaperones by speaking to any member of staff. We saw posters informing patients and ward visitors about this.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Catering staff visited DPU often to offer patients hot meals and drinks.

Staff had access to communication aids to help patients become partners in their care and treatment. The service’s LD nurse could support patients by being kind, patient and understanding with people who had a range of communication needs. Patients with additional or complex needs were identified at pre-admission and would then be allocated to receive care at the best place suited to their needs.

**Access and flow**

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

**Average length of stay**

Managers monitored waiting times. However, they did not always ensure patients could access services when needed and receive treatment within agreed timeframes and national targets. Service leads had carried out a great deal of work to reduce waiting times. For example, the service had speciality specific ring-fenced surgical wards for orthopaedic elective cases. This had helped reduce patients’ length of stay from 7-8 days a year ago down to 3-4 days average.

The service’s upper gastrointestinal (GI) team achieved most of their applicable cancer waiting times standards. We saw a table showing their seven pathway targets from November 2018 to November 2019. Three of their seven targets had been met for every month. All those percentages below 93% were highlighted for improvement. The team missed the 62-day GP target most frequently. This was missed for eight of the 13 months data given, which ranged between 76.9% and 59.5%.

At the time of our inspection this team were recruiting extra staff to provide more support. They had accessed funding through the east of England cancer alliance. The service aimed to further improve compliance against the forthcoming 28-day faster diagnosis standard, through nurse specialist and diagnostic capacity.
The service had improved the experience of colorectal patients, whose numbers had doubled in the last year using the 'straight to test' pathway. For example, the service triaged 60-80 year old patients with iron-deficiency anaemia for suspected lower gastrointestinal (GI) cancer with a straight to test colonoscopy and upper GI endoscopy. We saw referral form triage and investigation guidance for clinicians. The service had a 62-day or less East of England best practice pathway for suspected and confirmed colorectal cancer patients.

The service recognised their waiting list size problems and responded as a division.

The service’s referral to treatment (RTT) waiting list had increased, with a high level of demand for cancer and urgent referrals in place of longer waiting routine patients. A number of the service’s vascular patients were waiting for interventional radiology (IR) which was expanding capacity to meet demand from April 2020. The service had taken measures to address the demand for IR services. For example the service had increased IR to 5 “long” days. A day case service was introduced for appropriate patients in December 2014 to reduce patient bed requirements and prevent delays whilst they waited for a bed.

The service allocated extra capacity offered by cardiology in the shared suite of one day per week from November 2019. However, the IRU nursing establishment was too small to utilise this capacity except on an ad-hoc basis.

However, these measures did not release enough capacity to reduce the waiting list backlog or cope with unpredictable peaks in activity. Both inpatient and outpatient IR services demand exceeded capacity. This meant there was a serious risk to patient safety whilst waiting for an appointment. Specialty specific issues related to IR unit capacity were vascular surgery, renal dialysis maintaining patency of and recovering thrombolised AVFs and gastroenterology such as liver biopsies and PTC drainage.

The service had considered and reviewed capacity issues and risk in other divisions. For example, ophthalmology assessed the result of their three very old cameras failure which without repair or replacement would be cancellation and postponement of clinics. This could stretch to several hundred cancelled appointments and impact upon the service meeting their objectives. The implication for ophthalmology patients was a delay in diagnosing and treatment of diabetic retinopathy.

However, one patient on Docking ward told us they waited four hours for a suitable side room.

We saw in the day procedure unit (DPU) cancellations led to increased service demand on the waiting list and delays to RTT times.

The service could not always safely manage medical outlier patients from other wards. For example, Edgefield urology ward staff reported that on one occasion 12 out of 13 patients were medical outliers with 9 different medical specialties involved in their care. This meant different consultants were needed to give nursing staff timely feedback and made coordinated ward rounds difficult.

We saw the daily DPU inpatient escalation figures for the last four months from September to December 2019. Average daily inpatient numbers had slightly increased up until mid-December. Daily numbers varied between one and 21 but did not rise above 15 until mid-October as a result of increased patient capacity. This meant the DPU’s Lion and Golden bays was increasingly unable to function for its intended purpose of treating paediatric patients as their procedures were cancelled.

We spoke to the patient flow coordinator who explained the standard operating procedure (SOP) for escalation was largely ignored. The service had boarded over 300 medical patients onto
surgical beds unplanned since the SOP was in place from November 2019. We reviewed the number of DPU patients who did not meet the SOP during November and December 2019. The highest daily number was 21 patients across four escalation wards on 17 December 2019; two surgical and two medical wards. 19 of these patients were not for next day discharge. No data was available for the Saturday to Sunday shifts as these were not staffed by DPU. On two occasions during early December handover sheets went missing. This meant DPU escalation staff starting their shift could not easily access inpatient numbers.

The highest number of patient breaches in one week was 85. This occurred the week commencing 25 November 2019. 46 of these had breached clinical suitability and 39 had breached the length of stay (LoS) by not meeting the discharge criteria. One patient stayed for six days, seven patients stayed for four days and eight patients stayed for three days.

The service monitored and recorded each breach and escalated them to management. However, one of the patient flow coordinators told us discussions around inappropriately escalated patients had stopped last year. Regular escalation meetings were held by the new Chief Operating Officer (COO) but with no representation from the medical division. Staff we spoke to saw the absence of medical representation as a lack of ownership and engagement with the problem.

Managers and staff worked to make sure patients did not stay longer than they needed to. The service’s day procedure unit (DPU) carried out nurse-led discharges for patients. This removed the need for doctors or ward clerks which could cause delays. Letters were printed out with all the relevant discharge information from theatre. Two unit-based patient flow coordinators helped ensure timely discharge. One of them told us that on average DPU treats 80 patients a day so they aim to ensure the service meets its 6-4-2 12-week list. This was six weeks for referral, four weeks to theatre and two weeks to finalise. A small percentage of their patients were not meeting these timeframes.

We heard theatres had improved at communicating with patients about the need to fast. Doctors asked patients to consent before the pre-operative meeting. We heard nurses could refer patients directly for hand surgery into the physiotherapy hand clinic. This was a drop-in service which helped facilitate post-operative exercises. The pre-operative assessment staff had regular meetings with the orthopaedic assessment teams. They tried to theme clinics so that one nurse could provide a specific service such as urology or breast. All nurses rotated around the services to maintain their competency.

Service leads reminded theatres and recovery staff to ensure all relevant parties were present for the WHO team brief for all elective cases and not to undertake this beforehand. This consisted of the lead operating surgeon, lead anaesthetist and theatre team. Staff were asked to mark this on the sheet if it resulted in any delays. However, they acknowledged in rare emergency circumstances where time was critical, the lead surgeon could be absent for the team brief if this was delegated to another surgical team member.

Service leads were aware of the DPU’s operational challenges. Reduced service capacity issues had been highlighted on the ward specific risk register. This detailed the admitting, warding, recovery and discharge capacity for elective programme patients through a DPU pathway.

Staff would talk to the divisional nursing director and chief of surgery if they had concerns on the day. In response to bad staff feedback about the unit’s transience, managers had increased the number of staff members in charge. For example, they had seconded to band 6 as ward staff rather than theatre staff were needed.

Service leads told us the DPU degree of escalation varied. The unit was worse on Fridays and how well they could anticipate pressures by checking PAS alerts depended on the surgeon on
shift. The service stood down elective patients the day before to stop same day cancellations. Leads had robust governance in place but they felt this was not ideal. The service had lost a million pounds of income through operations cancelled on the day before. This amount didn’t count operations which were not booked as these were harder to quantify. Theatre productivity was rising with utilisation around 80% up until February 2019.

We saw the service’s surgical same day cancellation rates from October to December 2019. During these three months there were 1,134 clinical and non-clinical same day cancellations, of which 408 were non-clinical. This was a cancellation rate of 13%. The service reported 348 28-day cancellations to the QMCO as per their guidelines. The QMCO is a provider-based return used to monitor the experience of NHS patients. The specialty with the highest number of overall same day cancellations was trauma and orthopaedics with 454 over the three months. They also had the most reportable 28-day cancellations with 93 during this period.

The service was unable to break these figures down into cancer and non-cancer surgery patients.

At the time of our inspection the service planned to open 120 new beds to help take pressure off the DPU and Gisling ward. With the extra capacity they hoped to return to November 2018 waiting list levels.

Paediatric patients of any age on the service’s emergency or trauma list could have their procedure performed in any theatres subject to the theatre team and anaesthetist’s approval. This helped the service facilitate reduced waiting times and bed occupancy. The under 8 only in the above list theatres, applies to elective patients only. However, theatres and recovery staff’s awareness of this was poor as they had made repeated requests for clarification.

The service struggled to accommodate child patients with limited paediatric beds on the Buxton ward. We heard elective paediatric lists were occasionally suspended with cancellations on the scheduled day of surgery. Staff told us some patients arrived without beds being available so they had to be accommodated elsewhere. This had consequent impacts in terms of acuity and skill mix as the ward was also part of the intensive treatment unit (ITU). For example, we heard about missed instances of care such as numbing cream not being applied or the anaesthetist and surgeon having to move into other ward areas so patients were not all on DPU. Staff also had further to escort patients between the Buxton ward to theatres and recovery.

Numbing cream reduced the pain of needle procedures, including injections, vaccinations and blood tests, as well as cosmetic skin procedures involving needles or lasers, such as tattoos or laser hair removal. Numbing cream was applied to the skin around 60 minutes before a surgical procedure and always covered the area with a suitable occlusive dressing.

The service was impacted by not treating paediatric patients during escalation periods. Normally the children’s ward managed at least one paediatric nurse per shift but these were not required for escalated adult inpatients. This meant the student experience was affected as they were unable to treat children and adult nurses had to work through their competency books. As the Buxton ward had no nurse-led patient discharge, staff had to await medical advice and a GP letter.

Service leads admitted they faced challenges treating child patients on the DPU and Buxton ward. At the time of our inspection the unit layout had potential safeguarding issues due to the inpatient escalation bays. A cross section of staff from theatres, wards, renal medicine and accident and emergency (A&E) met to discuss and pre-emptively respond to winter escalation pressures. The service had discussed several plans and ideas to transform the DPU vanguard into a children’s ward. The chief of surgery had walked around DPU areas to see where secure access and swipe doors should be installed. The service reminded staff in the June 2019 monthly newsletter to
record and document all staff who enter the operating theatre or recovery to review a patient. This included when another speciality surgeon or anaesthetist came to review or give advice in attendance.

The trust was still managing 52-week breaches below 10% of the 40 weeks wait position. The service had recently doubled its general surgical capacity. Service leads felt the 52-week problem was created by the healthcare environment. In the ten weeks before our inspection, the service had no patients waiting over 52 weeks, but this was getting harder to maintain.

We reviewed the service’s 52-week breach patient numbers and their percentage from December 2018 to November 2019. The total waiting list size for general surgery had increased by over 500 patients during the yearly period. The overall number of 52+ weeks wait patients was zero for six of the 12 months. The number was highest in January 2019 with 28 patients which amounted to 0.10% of patients overall. 16 of these patients were awaiting vascular surgery, five were awaiting urology, three plastic surgery, two general surgery and two in other specialties. Vascular surgery had the most 52+ week breaches over the period with 18 during December 2018 and 15 during January 2019.

The three specialties with the highest waiting list sizes in November 2019 were trauma and orthopaedics, ophthalmology and dermatology which all had over 4,000 patients. However, urology, vascular surgery, ear nose and throat (ENT) and oral surgery total waiting list sizes had reduced over the year.

Referral to treatment (RTT) waiting list numbers were based on submissions by type including vascular. At the time of our inspection the service was carrying out a piece of work around harm on waiting lists. They proactively contacted patients at 30-40 weeks to review the harm using route cause analysis (RCA). The service also incorporated paediatrics into clinical harm reviews and the longest waiting lists.

The discharge lounge nurse in charge told us their most common reason for delays was patient transport due to a lack of ambulances. Staff including the patient flow improvement matron managed delayed discharge by adhering to their standard operating procedure (SOP). For example, they did not accept referrals for patients on stretchers after 5pm. This required more staff and ambulance crew to pat slide patients safely. After 5pm the service carried the risk patients on stretchers could not be discharged before the lounge closed at 7.30pm. The SOP mitigated this risk by ensuring the nurse in charge (NIC) would contact to the site operational team (SOT) at 18:45 with the number of patients still awaiting discharge and their planned times. At 19:30 the NIC would escalated to the SOT when an alternative location onsite for the patient to wait would be found.

We saw the discharge lounge’s SOP which complied with NICE guidance. This was going to the emergency and urgent care board on 21 February 2020 for review and approval. The SOP outlined the discharge process by ensuring patients met the admission criteria for the discharge suite. Inpatient ward staff had to book a chair or bed with any specific individual patient needs such as pressure relieving equipment prior to the suite accepting a patient handover. Staff also had to complete a discharge checklist, RAT assessment and Waterlow pressure area risk reassessment as recommended in the trust policy for prevention and the care of pressure ulcers.

We read on average only 3.3% of the trust’s discharges were completed before 10:00. In hospitals with high performing patient flow this figure is nearer 25%. Most of the service’s patients were discharged between 15:00–18:00 hours due to delays. The service’s delays in bed availability contributed to delays in patient flow from admission areas and impacts on the patient experience and national targets.
Trust Level – elective patients

From July 2018 to June 2019 the average length of stay for patients having elective surgery at the trust was 3.6 days. The average for England was 3.8 days.

- The average length of stay for patients having elective trauma and orthopaedics surgery at the trust was 3.6 days. The average for England was 3.7 days.
- The average length of stay for patients having elective urology surgery at the trust was 2.5 days. The average for England was 2.4 days.
- The average length of stay for patients having elective general surgery at the trust was 5.5 days. The average for England was 3.9 days.

Elective Average Length of Stay – Trust Level

Note: Top three specialties for specific trust based on count of activity.

Trust Level – non-elective patients

From July 2018 to June 2019 the average length of stay for patients having non-elective surgery at the trust was 3.2 days. The average for England was 4.6 days.

- The average length of stay for patients having non-elective general surgery at the trust was 3.4 days. The average for England was 3.6 days.
- The average length of stay for patients having non-elective urology surgery at the trust was 1.7 days. The average for England was 2.6 days.
- The average length of stay for patients having non-elective plastic surgery at the trust was 1.0 days. The average for England was 1.5 days.

Non-Elective Average Length of Stay – Trust Level

Note: Top three specialties for specific trust based on count of activity.

Norfolk and Norwich University Hospital - elective patients

From July 2018 to June 2019, the average length of stay for all patients having elective surgery at Norfolk and Norwich University Hospital was 3.8 days. The average for England was the same.

- The average length of stay for patients having elective trauma and orthopaedics surgery at
Norfolk and Norwich University Hospital was 4.1 days. The average for England was 3.7 days.

- The average length of stay for patients having elective urology surgery at Norfolk and Norwich University Hospital was 2.5 days. The average for England was 2.4 days.
- The average length of stay for patients having elective general surgery at Norfolk and Norwich University Hospital was 5.5 days. The average for England was 3.9 days.

Elective Average Length of Stay - Norfolk and Norwich University Hospital

Norfolk and Norwich University Hospital - non-elective patients

From July 2018 to June 2019, the average length of stay for patients having non-elective surgery at Norfolk and Norwich University Hospital was 3.2 days. The average for England was 4.6 days.

- The average length of stay for patients having non-elective general surgery at Norfolk and Norwich University Hospital was 3.4 days. The average for England was 3.6 days.
- The average length of stay for patients having non-elective urology surgery at Norfolk and Norwich University Hospital was 1.7 days. The average for England was 2.6 days.
- The average length of stay for patients having non-elective plastic surgery at Norfolk and Norwich University Hospital was 1.0 days. The average for England was 1.5 days.

Non-Elective Average Length of Stay - Norfolk and Norwich University Hospital

Norfolk and Norwich University Hospitals NHS Foundation Trust - elective patients

From July 2018 to June 2019, the average length of stay for patients having elective surgery at Norfolk and Norwich University Hospitals NHS Foundation Trust was 2.7 days. The average for England was 3.8 days.

- The average length of stay for patients having elective trauma and orthopaedics surgery at Norfolk and Norwich University Hospitals NHS Foundation Trust was 2.8 days. The average for England was 3.7 days.
- The average length of stay for patients having elective spinal surgery at Norfolk and Norwich University Hospitals NHS Foundation Trust was 1.2 days. The average for England was 1.5 days.
England was 3.9 days.

- The average length of stay for patients having elective ear, nose and throat (ENT) surgery at Norfolk and Norwich University Hospitals NHS Foundation Trust was 1.0 days. The average for England was 2.1 days.

**Elective Average Length of Stay - Norfolk and Norwich University Hospitals NHS Foundation Trust**

![Bar chart showing average length of stay](chart.png)

*Note: Top three specialties for specific site based on count of activity.*

*(Source: Hospital Episode Statistics)*

Managers made sure they had arrangements for surgical staff to review any surgical patients on non-surgical wards. Service managers told us they effectively managed surgical patients so they were never on non-surgical wards or areas. Where a patient on a non-surgical ward required surgery, they were transferred to a surgical ward.

The chief of surgery told us the division was moving towards 24/7 specialist availability for consultants of the day and week. The senior decision maker did not hold clinics which sent a clear signal to teams.

Service leads told us no consultants refused to visit accident and emergency (A&E) when asked to see patients and the emergency response unit (ERU) always arrived quickly. They felt within the surgical emergency assessment unit (EAUS) there was room for acute assessment so the service was trying to protect that area by escalating to others such as the day procedure unit (DPU).

At the time of our inspection the Cringleford ward had one medical patient, which they told us was normal for this time of year. This impacted on their ward flow.

Discharge notes were sent to the GP electronically.

Managers worked to minimise the number of surgical patients on non-surgical wards. We read about the gynaecological service’s nurse-led and home medical management of miscarriage depending on women’s need and gestation. This helped staff improve women’s experience and acted as admission avoidance.

Continued escalation into the day procedure unit was impacting on elective surgery for children and adults. The DPU matron told us procedures were being cancelled as the space was used by escalated adult inpatients. Approximately 20 elective adult cases were cancelled a week. The matron suggested to their manager that DPU Lion and Golden escalation bays should be set up and staffed for use as a ward.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From September 2018 to August 2019 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was lower than the England average. The percentage of patients at the
trust referred for treatment within 18 weeks ranged from 55.0% to 59.1%. This was lower than the England score which ranged from 63.3% to 68.3%.

Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

From September 2018 to August 2019 the trust’s referral to treatment time (RTT) for admitted pathways for surgery were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery for two specialties.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td>70.6%</td>
<td>61.5%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>59.4%</td>
<td>54.5%</td>
</tr>
</tbody>
</table>

Five specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgery</td>
<td>60.2%</td>
<td>72.0%</td>
</tr>
<tr>
<td>Urology</td>
<td>59.5%</td>
<td>74.6%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>55.6%</td>
<td>78.6%</td>
</tr>
<tr>
<td>Ear, nose &amp; throat (ENT)</td>
<td>48.2%</td>
<td>59.9%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>31.4%</td>
<td>58.1%</td>
</tr>
</tbody>
</table>

Cancelled operations

Managers worked to keep the number of cancelled appointments/treatments/operations (delete as appropriate) to a minimum. The surgical division has redesigned and bolstered their surgical and medical ambulatory care service and protected their day surgery space. This has led to a reduction in cancelled surgery.

The service had greatly reduced cancellation of cancer patient surgery arising from a lack of critical care beds. This was done by making investments in cancer pathway-related capacity, equipment and staff.

The service reviewed all patients who have waited longer than 18 weeks, assessed them and acted upon harm. This was done at a scrutiny committee chaired by the medical director.

When patients had their appointments/treatments/operations (delete as appropriate) cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation, then this is recorded as a breach of
the standard and the patient should be offered treatment at the time and hospital of their choice.

Over the two years from Q2 2017/18 to Q1 2019/20, the percentage of cancelled operations where the patients were not treated within 28 days at the trust was consistently higher than the England average.

Percentages increased in Q4 2017/18 and Q1 2018/19. Percentages decreased in Q2 2018/19. However, from Q3 2018/19 to Q1 2019/20, percentages increased quarter on quarter.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - Norfolk and Norwich University Hospitals NHS Foundation Trust**

![Graph showing the percentage of cancelled operations over two years.]  

**Cancelled Operations as a percentage of elective admissions - Norfolk and Norwich University Hospitals NHS Foundation Trust**

![Graph showing the percentage of cancelled operations as a percentage of elective admissions over two years.]  

Over the two years, the percentage of cancelled operations at the trust was generally higher than the England average. The highest percentage of cancelled operations were reported in Q4 2017/18, and Q4 2018/19. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

Staff did move patients between wards at night. We reviewed the number of surgical inpatient out of hours (OOH) night moves between 10pm and 6am from September to November 2019. These numbered 193 in total over the three months. The most total inpatient ward moves occurred in October which numbered 87. This averaged 2.8 inpatient moves per day after 10pm. However, the service did not record which wards patients were moved from and to.
Managers and staff worked to make sure that they started discharge planning as early as possible. For example, staff on the Cringleford ward started discharge planning for transport services upon admission for elective orthopaedic patients.

However, we saw nine patients were still awaiting discharge on the Edgefield ward at 4pm on 10 December 2019. Staff told us this was for a number of reasons including patients awaiting transport, awaiting or rechecking old results, and a trial without catheter (TWOC) being performed for a patient with an indwelling urethral catheter.

Staff planned patients’ discharge carefully, particularly for those with complex mental health and social care needs (AMSAT). We observed a Cringleford ward MDT red to green meeting with a few Allied Health Professional (AHP) therapists. Staff discussed and considered the access to and size of home or community care packages needed for their elective orthopaedic patients. They referred patients to the mental health support team if they felt suicidal or depressed.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. We saw the number of delayed discharges by ward from December 2018 to November 2019. The highest total number of delayed discharges bed days across all wards was 211 in May 2019. This was an average of 6.8 per day. The highest number by ward was 123 in April 2019 on Gateley ward. Gateley ward also by far had the highest total number, with 519 over the 12 months. The most common reason for these delayed discharges was patients awaiting further non-acute services including in the community. The next most common reasons were patients awaiting care packages in their own home or residential home placements or availability. These totalled 605 bed days over the 12 months. However, total delayed discharge bed day numbers had reduced in the months ahead of our inspection.

Staff supported patients when they were referred or transferred between services. For example, the Aylsham suite / discharge lounge administration manager liaised with a Coltishall ward surgeon a week ahead to plan timely patient transport for an elective patient.

**Patient moving wards per admission**

The trust indicated that the system they used does not record if ward moves were for clinical or non-clinical reasons.

The trust reported that patients with a high number of transfers are reviewed internally using a report produced on a monthly basis. Papers are prepared for the Patient Experience and Engagement Group on this topic and, as part of this paper, analysis are undertaken, and recommendations made.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

**Patient moving wards at night**

From August 2018 to July 2019 there were 3,580 patient moving wards at night within surgery. The surgical emergency assessment unit had the highest number of ward moves at night, 71.1% (2,545).

Excluding the surgical emergency assessment unit, the same day admission unit had the highest number of ward moves with 17.2% (178), followed by Gateley ward with 16.3% (169), Edgefield ward with 13.0% (135) and Docking ward with 12.0% (124). Ward moves increased over the winter months, reaching the highest point in January 2019.

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)
Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. We heard the example of a complaint about noise levels from overnight staff. Staff addressed this by sitting in different areas around the ward, rather than all at the front desk which also helped patient oversight. Staff had a nominated ‘noise at night’ champion to try and reduce the amount of unnecessary noise. Staff also closed doors and issued patients earplugs. However, one patient we spoke to said their ward could still be noisy overnight.

One patient on the Docking ward told us they had been approached to complete an inpatient experience survey.

The service clearly displayed information about how to raise a concern in patient areas. Staff gave patients who wished to complain leaflets to contact the patient advice and liaison service (PALS). Docking ward staff told us their ward sister would be the first port of call and potentially their freedom to speak up guardian (FTSUG) who they knew by name. The ward sister held open sessions for discussing complaints with staff. These were advertised on the staff notice board in the kitchen.

We saw the service dashboard on wards featured the top three complaint categories. These were delays in patients receiving treatment, poor communication and attitudes of staff. Two examples of each category were given below and service leads were working to reduce the number of last minute cancelled appointments and the size of long-term waiting lists for operations.

Staff knew how to handle complaints, but they did not always understand the procedure. Staff we spoke to on the docking ward knew how to deal with complaints. They would try to help and refer to the nurse in charge if needed.

The trust had a complaints procedure which was updated in December 2019 and publicly available on the trust’s website. We saw the procedure where the trust target was to complete most complaint investigations within 25 working days.

Managers investigated complaints and identified themes. The nurse in charge on Coltishall ward told us she encouraged nurses to write statements for clearer governance and accuracy if they anticipated patient complaints. Service leads told us many of their elective patient complaints due to cancellations related to the day procedure unit (DPU) ward areas.

Summary of complaints

Trust level

From August 2018 to July 2019 the trust received 232 complaints in relation to surgery at the trust (21.5% of total complaints received by the trust).

The trust took an average of 33.4 working days to investigate and close complaints. The trust’s complaints policy states that complaints should be investigated and closed as agreed with the complainant.

Five complaints were still open at the time of reporting, these had been open for an average of 74.4 working days.
A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communications</td>
<td>52</td>
<td>22.4%</td>
</tr>
<tr>
<td>Clinical treatment - surgical</td>
<td>48</td>
<td>20.7%</td>
</tr>
<tr>
<td>Admission, discharge and transfers</td>
<td>26</td>
<td>11.2%</td>
</tr>
<tr>
<td>Appointments including delays and cancellations</td>
<td>26</td>
<td>11.2%</td>
</tr>
<tr>
<td>Patient care including nutrition/hydration</td>
<td>24</td>
<td>10.3%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>9</td>
<td>3.9%</td>
</tr>
<tr>
<td>Privacy, dignity and wellbeing</td>
<td>9</td>
<td>3.9%</td>
</tr>
<tr>
<td>Facilities</td>
<td>6</td>
<td>2.6%</td>
</tr>
<tr>
<td>Values and behaviours (staff)</td>
<td>6</td>
<td>2.6%</td>
</tr>
<tr>
<td>Trust administration</td>
<td>5</td>
<td>2.2%</td>
</tr>
<tr>
<td>Clinical treatment - obstetrics and gynaecology</td>
<td>5</td>
<td>2.2%</td>
</tr>
<tr>
<td>Clinical treatment - anaesthetics</td>
<td>4</td>
<td>1.7%</td>
</tr>
<tr>
<td>Clinical treatment - general medical</td>
<td>3</td>
<td>1.3%</td>
</tr>
<tr>
<td>Commissioning services</td>
<td>2</td>
<td>0.9%</td>
</tr>
<tr>
<td>Prescribing errors</td>
<td>2</td>
<td>0.9%</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>2</td>
<td>0.9%</td>
</tr>
<tr>
<td>Consent</td>
<td>2</td>
<td>0.9%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>232</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From August 2018 to July 2019 there were 481 compliments received for surgery (including teams that work across both surgery and critical care) at the trust (25.8% of all received trust wide).

A breakdown of compliments by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cromer Hospital</td>
<td>14</td>
<td>2.9%</td>
</tr>
<tr>
<td>Norfolk and Norwich University Hospital</td>
<td>467</td>
<td>97.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>481</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Since January 2019, the trust aimed to improve collection and recording of compliments. Compliments are reported monthly to the Patient Engagement and Experience Group (PEEG) and there is a monthly analysis of themes. Divisions can access their data for use at local level and for sharing and learning from compliments. Trust wide themes are identified to show how important care, kindness and staff attitude are to the positive experience of patients. Dignity is a key positive theme. A selection of compliments is shared, and individual wards and areas display and shared amongst teams.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Staff knew how to acknowledge complaints and patients received feedback from managers after
the investigation into their complaint. The trust had an online tool to compile and report on compliments and complaints. Service leads reminded staff to make their department’s admin support aware of any thank you cards, letters and gifts so they could upload these and share the positive feedback.

Managers shared feedback from complaints with staff and learning was used to improve the service.
Is the service well-led?

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They supported staff to develop their skills and take on more senior roles. However, managers were not always visible and approachable in the service for patients and staff.

The surgical division was led by a triumvirate of chief of division, director of nursing and director of operations. The divisional structure was introduced in April 2016. The chief of division and the operations director were both comparatively new in post on our last inspection. As a result, their roles and the divisional structure were better embedded. Divisional leaders had been given increasing autonomy to manage the divisional strategy and business. The leadership told us that they were making headway with their objectives but had also identified areas of support they required. The triumvirate met informally weekly to ensure clarity and consistency of communication.

Staff spoke highly of their local leadership in ward areas. Ward managers we spoke with felt supported by their matrons and senior matrons for the division. Nursing staff described managers as supportive and told us they felt able to raise concerns. We saw trust board names and faces on ward reception boards to improve awareness and visibility of the executive team (ET). Each theatre unit (main and day procedure) had boards outlining the division’s governance structure. These boards had been in situ and were kept up to date since 2018.

However, in theatres a clinical facilitator on the practice development team told us they did not value their manager’s leadership skills. A band 6 in emergency theatres told us they had little involvement with the matron. Practice development staff told us they never saw their manager and they didn’t reply to emails. A practice development nurse told us their manager did not use them as they challenged decisions.

Theatre staff told us the workforce planning was not proactive. For example, the service had failed to sanction three applications for an anaesthetist course.

On our last inspection the service had ongoing issues with referral to treatment times, capacity, access and flow and staffing over many years that had not been fully addressed.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders monitored progress. However, staff did not always understand or know how to apply the vision and strategy.

The trust’s vision was ‘to provide every patient with the care we want for those we love the most’.

The trust’s values were PRIDE;
People focused
Respect
Integrity
Dedication
Excellence

Most staff we spoke to such as Docking ward nurses were aware of the trust’s values which were clearly displayed around the hospital.

The divisional leadership had a clear strategy for the division. This was to ensure cancer, elective and non-elective surgery were balanced to ensure all patients had access to the right treatment at the right time at a tertiary centre. Staff awareness of the division’s broader vision and strategy had improved since our last inspection due to improved communication and visibility of leaders. More recently divisional leads held catch up meetings with notes for distribution as they developed their response to the Covid19 infection outbreak.

The divisional leadership described work with the strategic transformation partnership (STP) that impacted the division. This included integrating services such as ENT and urology with other NHS trusts and ensuring the pathways were clinically led, both medical and nursing.

The clinical educators and training team told us every four months they worked to embed the values as well as culture, dignity and respect. This training was open to all staff bands.

Service leads had rolled out train the trainer courses in several area for future sustainability.

Culture

Staff felt respected and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. Patients, their families and staff could raise concerns without fear. However, the service did not always have an open culture and staff did not always feel supported.

The new chief nurse had put measures in place to improve the culture. One example was the monthly serious incident group (SIG) meetings which shared learning and feedback. All divisional staff were encouraged to attend. The ward or deputy sister with matron support planned time to allow Edgefield staff to be released from the ward.

The divisional nursing director told us they were proud of the work done in theatres. They felt the service had made a cultural shift to become more learning-orientated, for example responding to incidents. The service had reviewed the governance structure for theatres so they now had a band 7 pulling everything together, for example equipment changes and prostate-specific antigens (PSAs).

The service’s theatres and recovery staff produced a monthly newsletter called gazette. This was comprehensive yet easy to read and gave staff the latest divisional updates. The newsletter started nearly two years before our inspection. This provided staff with a brief on service developments, safety, medicines management, incident learning and the incident reporting system, best practice reminders, service performance summaries, team celebrations and colleague achievements. The 2019 annual summary showcased highlights from that year’s 12 editions.

Staff felt supported by their colleagues and described it as a very caring, friendly team. Bank staff felt they were treated the same as the permanent staff. Staff felt able to raise concerns. They were aware of the trust’s freedom to speak up guardian and knew how to contact them.
However, a mixed culture remained in theatres. A band 5 operating department practitioner (ODP) told us that band 7s and above could be more open to their ideas for change. We heard that concerns had been raised with the managers.

The service’s theatre communications across all theatre environments were supported by a wide range of tools. These included team meetings, newsletter briefings and quick read bulletins posted in rest rooms. The quick read bulletins were called the ‘toilet times’ due to their location. They delivered important messages about practice, safety or support in an accessible way.

The division’s theatre management group (TMG) was the main theatre departmental business meeting. It met monthly since late 2018. The meeting agenda and papers were structured around the five domains. These papers and domains were then replicated each month on the theatre communication boards. This ensured the five domains were always covered at TMG. This also meant the whole department could see TMG’s latest information, actions and initiatives. We saw samples of the communications board and the TMG papers for December 2019.

A student nurse told us they were told off by a health care assistant (HCA) in front of a patient about a bedsheet rather than being taken to one side. All three student nurses on the Edgefield ward did not feel as supported as they expected. However, they had a close working relationship with their clinical educator.

At the time of our inspection the Cringleford ward had won ward of the year.

**Governance**

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Leaders had divisional accountability to monitor and review their domain metrics and knew how all domains were performing.

We heard new governance structures and staff were having a positive impact on services. Divisional leads told us the newer staff had degrees in risk and governance which helped them feel reassured, organised and gave them more scope. They said all divisional reports were sent to the sub-boards on-time.

We saw the service’s divisional governance triumvirate and meeting structures. At the time of our inspection there were a few vacant posts such as the Cromer operations manager, a senior matron and trauma and orthopaedics matron. The management board sat at the top of the divisional meeting structure, underpinned by four sub-boards; safety and effectiveness, non-clinical, workforce and carer and patient experience. These all fed into the divisional performance meeting which received updates from all divisional meetings via the divisional board. The safety and effectiveness sub-board was underpinned by the risk oversight committee, recognise and respond committee and trauma board.

One nurse practitioner told us they attended local governance level meetings but matrons and consultants were the most senior staff present.

The service took divisional accountability. We saw the service’s performance accountability framework (PAF) across the four domains of quality, workforce, finance and performance from September to November 2019. This was a divisional monthly quality report with all their national standards and latest internal targets. Overall the division was performing best in quality and worst in performance and finance.
Divisional leads monitored and reviewed the PAF and PAFs from other triumvirates. Any red divisional domains prompted extra meetings. Some metrics had variables such as theatre utilisation. Service leads could drill down into the detail with help from the information support team.

The service’s governance manager and their team worked to distil their governance strategy onto one single A4 page.

The service held monthly risk and safety governance meetings which were open to all staff. These were advertised in October 2019’s monthly newsletter sent to all theatres and recovery staff.

The service’s risk and safety meetings supported the essential care scrutiny panel (ECSP). The trust’s corporate governance manager maintained an attendance list for the panel. The panel ensured all pressure ulcers were scheduled to be reviewed no later than 10 days after identification. Team staff also checked the incident reporting system before the panel for any updates to patient’s harm level validation. We saw the ECSP’s terms of reference (ToR) which was awaiting panel approval. The panel’s purpose was to ensure a holistic review of all hospital acquired pressure ulcers categories two and above including unstageable. They ensured nutrition related incidents and inpatient falls (where the patient graded moderate harm or above) were questioned and analysed to ensure identification of the contributory factors, root causes and lessons learnt. The ToR also had minimum attendance requirements to be quorate. If the deputy chief nurse was unavailable to chair, this would be deputised to a divisional nursing director. The panel was supported by representatives from the expert groups of tissue viability, a therapist, dietician/nutritional team nurse and safeguarding. We checked attendance lists from the last three panels and found these minimum requirements were adhered to.

The service’s ECSP planned a meeting to review their panel’s current format and serious incidents round table reviews. They planned to evolve the current review processes to ensure they were streamlined as well as enhance learning and improve MDT involvement.

At the time of our inspection the panel’s next steps were to improve the sharing of learning across the governance team, patient safety teams, specialist and clinical teams. All these teams had planned a meeting late January to review the current processes and determine any improvements or amendments needed. Perfect ward questions were currently being reviewed to improve the collection of data as well as support and drive the required improvements identified through thematic reviews. The service had various quality improvement (QI) projects registered on the trust’s life QI platform. These were being progressed to test new ways of working, measure improvements and identify changes to practice that were appropriate to spread and embed into practice, including the amendment of policies and guidelines.

The chief nurse told us the serious incident group (SIG) was structurally well embedded.

Theatre governance were looking for staff to develop and facilitate practice audits across departments. Staff were asked if they were interested in improving the service’s standards of care and developing themselves to learn new skills. This was an open opportunity for all staff regardless of level and advertised in June 2019’s monthly newsletter.

However, on the day procedure unit (DPU) escalation wards, handover sheets went missing on two occasions during early December. This meant service leads and senior staff at that time would had poor oversight of inpatient numbers and risk.

**Management of risk, issues and performance**

**Leaders and teams used systems to manage performance effectively. They identified and**
escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. However, staff did not contribute to decision-making to help avoid financial pressures compromising the quality of care.

Service leads monitored and reviewed the risk of patient harm from unintended non-adherence to trust policy by staff due to continual increased workload as a result of low staffing numbers causing fatigue.

The service had improved risk oversight and management since our last inspection. The main risks staff told us about were on the risk register. One example was falls, and a lack of patient visibility. Staff ensured patients with dementia were in the rooms nearest the front desk.

We saw the top three divisional risks for the service. All three risks were rated as high and scored 16 out of a possible 25. Risks were reviewed monthly. At the time of our inspection these risks had been reviewed within the last month. The oldest risk had been on the divisional risk register for six and a half years but the service had taken effective measures to address this. The top three divisional risks were included in the service’s monthly newsletter. Theatre and recovery staff were prompted to know the biggest risks in their own department.

We raised the lack of effective systems for identifying risks as a warning notice on our last inspection.

The oldest risk was around the increase in ophthalmology outpatients referrals due to national priorities and proactive screening. Patients awaiting review were at risk of their eye conditions and diseases progressing which could cause total or partial sight loss. The service previously met this demand with extra Saturday clinics which required more follow up appointment slots but with no extra medical retinal capacity identified. The service could not follow up patients within required timeframes. For example, patients referred from the eye screening service were not meeting national screening committee standards for referral to treatment (RTT).

The service had taken numerous measures to address this risk. For example, they diverted some patients to other pathways appropriate to their condition such as diabetes and nurse-led glaucoma clinics. Consultant leave was backfilled to avoid cancelling clinics. Extra clinics were run on an ad-hoc basis when possible, in an attempt to reduce the backlog of follow up appointments. The division reviewed all templates to identify potential for converting slots to follow up slots. They were also looking to identify any further capacity.

The service set up a milestones log to address ophthalmology high impact intervention in April 2018. They managed, monitored and reviewed the risk of harm to ophthalmology patients, for example by developing failsafe prioritisation processes and policies. Most milestones were completed on time, but a few were completed late. One milestone around the consultant oversight over middle grade and junior doctors to reduce unnecessary reattendance was overdue. The service had mitigated this ongoing risk by introducing virtual clinics for some conditions in June 2019. They also ensured a new rotation of doctors would enable a more robust discharge process in August 2019.

The service audited follow up appointments to identify patients’ target and actual follow up times, the clinical impact of delay, and the grade of the decision maker for target follow up times. The audit enabled the service to review appropriateness of follow up timings, in order to inform staff and maximise use of follow up slots. At the time of our inspection the service was carrying out a review to see if patient numbers could be reduced quicker than the current rates.

The second risk affected dermatology and plastic surgery’s equipment provision. The service needed tablets which allowed staff to photograph Mohs surgery and map tumours as they removed them. Paper and pencil was inadequate to draw lesions and their sometimes complex
defects as it gave no indication of their depths. 600 patients a year were treated by the Mohs service. However, since our inspection service leads had archived this risk at their divisional risk review meeting in February 2020 after carrying out further work. Tablets were reviewed and software was approved by the information governance team. Tablets were trialled by two consultants, and the service planned to order more if they were pleased with the results.

The service was close to mitigating the risk as they had received the tablets which were awaiting configuration. This would allow safe image transfer and meet general data protection regulations (GDPR). GDPR is a European Union law which applied from May 2018 around data protection and privacy for all individual EU citizens.

The third risk was around injury to patients and visitors during the trust’s inpatients escalation into the day procedure unit’s (DPU) Lion and Golden bays if they wander into restricted areas such as anaesthetic rooms, operating theatres, recovery or the Reedham/Shotesham wards. As all restricted areas were unstaffed out of hours, injured patients or visitors may not be found until the next day. The service had fully assessed risks of equipment damage or theft, information governance data breaches and fire and explosion if patients or visitors smoke, despite the trust operating a smoke free policy.

The service had taken measures to mitigate this risk such as erecting portable/mobile screens in the corridor between the bays and DPU with ‘no entry’ signage displayed. Staff escorted patients and visitors who ask to visit the canteen or similar through the department to the main hospital corridor to exit the building. The service had considered a call bell system from the main corridor entrance to accommodate this. The site team maintained safe staffing levels within the escalation areas. Swipe entry doors between Lion and Golden bays and the DPU were awaiting installation.

We also saw the service’s ward specific risk registers for DPU, vascular and ophthalmology. The service anticipated and responded to extra financial implications. For example, the vascular risk register included the costly use of agency staff and overtime as a result of Denton ward’s inexperienced staff due to high turnover. The service often had to cover the shifts with break glass agency staff members.

The service had increased reported incidents of sub-optimal care on the Edgefield urology ward. In response a chief executive oversight (CEO) assurance panel recommended the phased transition of new staff into a challenged team. Service leads recognised many new staff were inexperienced and the old staff were disheartened following ward changes. They also recommended a urological nurse practitioner promotion around joint working with medical and nursing teams. This allowed experienced urological nurses to be a consistent teaching and educational tool for nurses and junior doctors. For example, staff were supported in learning to complete essential drugs lists (EDL) and continue their improvement within the patient pathway.

**Information management**

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required. However, information systems were not integrated and user friendly.

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Information systems were not always integrated and secure. A divisional deputy sister told us many of the ward’s IT systems were not compatible or well linked. Staff told us when IT equipment occasionally broke it was sometimes not repaired for several days. A lack of investment and the
continued use of aged IT infrastructure had been on the trust’s risk register since August 2018. This was one of the trust’s 17 joint highest scoring risks with the highest possible score of 20. The trust had ten more IT related risks on their corporate risk register all with the maximum risk scores of 20.

Divisional leads told us they received the necessary information to ensure they effectively monitored performance and finance. The division compiled and considered a monthly integrated performance report. This detailed finance and performance metrics giving an overview of the division. This was challenged by members at divisional board and other board sub-committees. We saw reports were sufficiently detailed to allow granular discussion of issues on individual wards.

Ward dashboards were sent monthly to ward managers which they discussed with their matron and senior matron. There was also oversight from divisional and trust leadership. Managers we asked had a good knowledge of their ward dashboard, challenges and positive performance that was shown. At the time of our inspection the divisional triumvirate and central divisional teams such as the governance team were taking the next steps in improving their distribution of information.

We heard improved access to systems and hardware helped service efficiency. For example, divisional leads told us their weekly perfect ward combined audits were made quicker and easier by having access to mobile devices. Divisional staff told us the new internal incidents reporting system gave them easier access and oversight. Nursing staff were also complimentary about using the Safecare system to align staffing with patient acuity.

**Engagement**

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

The service had carried out a divisional board survey on engagement. Senior team leaders had independent coaching for development. The chief of surgery told us the idea came from his session to see if the divisional board focused on the right issues. They asked the deputy director of divisional operations to present their findings at the next divisional board meeting. The other half of this meeting was around decision making so all board members were part of these conversations about difficult issues.

The service carried out a quality improvement (QI) life project of self-rostering on the Docking ward over a trial period of three months. This had been found to improve staff retention, morale and work life balance. We saw another QI life project from October 2019 which established processes within main theatres and recovery to support staff and improve their wellbeing.

The service’s practice development and education (PD&E) team realised the need to help overseas nurses adapt and familiarise themselves over time at ward level despite having the requisite skills. Orientation packs were developed to provide them with information on local and practical resources such as buying a winter coat or finding the right bus.
Service staff could access a wellbeing service which helped them cope through a range of support appropriate to their own needs. This included telephone-based treatments, workshops, stress control, computer-based therapy, one-to-one work, signposting to community-based support and mental health first aid. The service organised events such as the mindful movement and relaxation session for world mental health day in October 2019 to calm the mind and reduce stress.

The service’s June 2019 monthly newsletter for theatres and recovery staff featured an article about the workplace health and wellbeing service. Service leads reminded staff of the need to be more aware and take care of their mental wellbeing to protect their workforce and colleagues in the workplace. They listed ten ways staff could look after their mental health and offered support if staff felt unable to talk to their line manager or matron.

However, in the day procedure unit (DPU) ward areas staff health and wellbeing were affected due to missed or delayed breaks and additional workload pressures. Service leads told us destructive practices occurred on DPU as the standard operating procedure (SOP) was regularly breached. They also acknowledge the lack of staff continuity/familiarity for those who were moved or agency staff which led to poor morale and stress-related absences and retention issues.

DPU staff told us the outlier escalation changes took the fun and enjoyment out of their job and added to their stress levels. A paediatric nurse became very emotional when explaining the impacts of escalation on the DPU. They felt the ethos of the department and teamwork had been destroyed by the current model which had a significant impact on staff morale. DPU service leads could not always be sure staff would come to work due to sickness, stress or after a challenging shift. They felt both staff and patients were treated as commodities rather than as people and were deeply upset care was potentially being compromised.

Service leads kept teams up to date with ‘you said, we did’ style feedback around routine escalation into the DPU. They supported this with updates from team meetings, briefings and communication boards.

Learning, continuous improvement and innovation

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

The service completed perfect wards audits in 39 individual areas, eight of which were outpatients. Each individual area had four different audit sections so in total there were 156 audit reports for one month. The audit sections were documentation, infection prevention control (IPC), daily department safety checks and weekly quality.

We saw a selected sample of these audits across four wards which all scored highly. The highest scoring audit was Denton ward’s daily department safety check with an overall average of 99% after 29 inspections. The lowest was Dilham and Edgefield’s documentation audits with an overall average of 85% although they had only completed one or two inspections each.

The surgical governance team sent monthly perfect ward reports to the ward/department teams. The teams were requested to review their performance for each audit and development a monthly plan for improvement with their area matron. The service followed up action plans and improvements at both the ward sisters meeting and the divisional performance meeting at the end of each month.
The service had shown innovation around staffing issues by creating additional role developments such as operating department practitioners (ODPs) and rehabilitation assistants in critical care. These roles helped staff respond to patient emergencies around airway management and gave surgical wards support across the hospital.

We heard about service innovations in surgery. These included the example of service development of intrabdominal chemotherapy.

The chief of surgery was proud of the fact surgical staff had the dedicated drive to develop a robotic programme on Saturdays as they had no capacity on weekdays. The service was also one of only three centres in the UK to offer abdominal liquid chemotherapy. They worked with ACIS Norfolk to integrate acute services across the county. Ear, nose and throat (ENT) partnership work with a neighbouring hospital trust was also ongoing.

Service leads told us about cross divisional working in obstetrics. We also saw evidence of cross divisional discussion underway between the essential care scrutiny panel and divisions about funding opportunities for a dedicated falls lead taking place ahead of budget setting from 2020/2021.

### End of life care

#### Facts and data about this service

The trust provided end of life care at Norfolk and Norwich University Hospital. End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

The Specialist Palliative Care Team (SPCT) consisted of 10 clinical nurse specialists and six palliative care consultants and delivered a seven-day service with outpatient provision. Rapid response to admissions via the emergency department (ED) was provided by a consultant who held an on-call mobile telephone.

The trust provided End of Life Care (EoLC) education to all staff groups. A multidisciplinary individualised EoLC care plan had been developed by Norfolk and Norwich University Hospital’s SPCT and had been adopted by all partner organisations in Central and West Norfolk. The care plan had been implemented in all adult wards.

The trust had an EoLC strategy which was available to all staff on the trust intranet. All wards had a palliative care link nurse and training sessions were provided by the SPCT. The integrated palliative care outcome scale (IPOS) measures were used for both inpatients and outpatients.

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

The trust had 2,352 deaths from March 2018 to February 2019.

*(Source: Hospital Episode Statistics)*
During our inspection we visited eight wards, the outpatient clinic, the Multi faith room, the mortuary and the bereavement office. We spoke with 30 staff including; doctors, consultants, nurses, mortuary staff, porters, Chaplains, administration staff and bereavement office team. We spoke with three relatives and seven patients.

We reviewed a variety of records including medical records of 10 patients who were recently deceased and five records of patients who were currently receiving care from the specialist palliative care team (SPCT).

**Is the service safe?**

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory Training**

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

**Mandatory training completion rates**

Nursing staff received and kept up-to-date with their mandatory training was a combination of face to face and e-learning sessions.

The trust set a target of 90% for completion of mandatory training. The trust provided end of life care services at Norfolk and Norwich University Hospital only.

A breakdown of compliance for mandatory training courses from August 2018 to July 2019 at Norfolk and Norwich University Hospital for qualified nursing staff in the specialist palliative care teams shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Venous thromboembolism</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Clinical record keeping</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention (level 2)</td>
<td>9</td>
<td>10</td>
<td>90.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety (slip, trips and falls)</td>
<td>9</td>
<td>10</td>
<td>90.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic life support</td>
<td>7</td>
<td>10</td>
<td>70.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In end of life care the 90% target was met for nine of the 10 mandatory training modules for which qualified nursing staff were eligible.

Staff received mandatory training in palliative care. Palliative and end of life care training was part...
of the induction programme for all medical and nursing staff joining the trust.

The mortuary and bereavement services completed mandatory and statutory training. Data provided by the trust showed the mortuary team were 100% compliant with training necessary for their roles, for example infection prevention and control.

Medical staff received and kept up-to-date with their mandatory training as a combination of face to face and e-learning sessions.

A breakdown of compliance for mandatory training courses from August 2018 to July 2019 at Norfolk and Norwich University Hospital for medical staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>12</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>10</td>
</tr>
<tr>
<td>Health and safety (slip, trips and falls)</td>
<td>15</td>
</tr>
<tr>
<td>Basic life support</td>
<td>14</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>11</td>
</tr>
<tr>
<td>Fire safety</td>
<td>14</td>
</tr>
<tr>
<td>Clinical record keeping</td>
<td>10</td>
</tr>
<tr>
<td>Information governance</td>
<td>13</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>13</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>10</td>
</tr>
<tr>
<td>Infection prevention (level 3)</td>
<td>10</td>
</tr>
</tbody>
</table>

In end of life care the 90% target was met for two of the 11 mandatory training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Data supplied by the trust at the time of our inspection showed specialist palliative care team (SPCT) medical staff were 100% compliant with mandatory training.

SPCT staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia as part of their induction and as part of safeguarding training within electronic learning modules.

Managers monitored mandatory training and alerted staff when they needed to update their training. This was monitored through the monthly end of life care dashboard.

Safeguarding

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

Safeguarding training completion rates

Nursing staff received training specific for their role on how to recognise and report abuse.
The trust set a target of 90% for completion of safeguarding training. The tables below include prevent training as a safeguarding course. Prevent aims to stop individuals from getting involved in or supporting terrorism or extremist activity.

A breakdown of compliance for safeguarding training courses from August 2018 to July 2019 at Norfolk and Norwich University Hospital for qualified nursing staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Prevent - level 3</td>
<td>9</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>10</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>8</td>
</tr>
</tbody>
</table>

In end of life care the 90% target was met for two of the three safeguarding training modules for which qualified nursing staff were eligible.

Medical staff received training specific for their role on how to recognise and report abuse. A breakdown of compliance for safeguarding training courses from August 2018 to July 2019 at Norfolk and Norwich University Hospital for medical staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>13</td>
</tr>
<tr>
<td>Prevent - level 3</td>
<td>11</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>12</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Training tab)

Data provided by the trust showed that at the time of inspection, SPCT medical staff did meet the safeguarding adults level 2 compliance.

Mortuary staff were 100% compliant with safeguarding adults level 2 training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff spoke about how they had recently treated a patient in receipt of end of life care from the traveller community. Staff understood the holistic needs of the patient in relation to their culture and traditions of being surrounded by a large number of family members. Staff were able to accommodate family members to stay with the patient overnight.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Four nursing staff we spoke with about safeguarding described how they would raise a safeguarding
concern and knew to access the trust intranet for information. One staff member described how they had raised a safeguarding concern after a relative had disclosed information of concern to them.

**Cleanliness, infection control and hygiene**

**Staff used infection control measures when visiting patients on wards and transporting patients after death.**

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Mortuary records from 29 October to 4 December demonstrated that staff cleaned refrigerators and hoists weekly.

Staff followed infection control principles including the use of personal protective equipment (PPE). SPCT nursing staff wore disposable gloves and aprons while providing personal care to patients. Mortuary staff wore disposable gloves and aprons when handling deceased patients and also used PPE when performing post mortems.

All staff followed good hand hygiene principles, washing their hands before and after patient contact and using hand sanitiser when entering and exiting the wards.

Staff cleaned equipment after patient contact. Mortuary cleaning records from 19 November to 12 December demonstrated that staff cleaned equipment such as body trays and the patient collection trolley between patients.

**Environment and equipment**

**The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.**

Staff carried out safety checks of specialist equipment in line with guidance. Refrigerator temperatures in the mortuary were consistently recorded on a computer system. An alarm sounded should the temperatures dropped below the required temperature. Faults on the fridges were alerted through the hospital switchboard to the mortuary and maintenance teams, who were available 24 hours a day to respond to any problems.

Mortuary equipment, such as trolleys, refrigerators, taps and air handling units were on a planned preventive maintenance (PPM) schedule and records provided by the trust showed they were all tested and serviced appropriately.

Specialist palliative care team administration staff ensured syringe pumps underwent service and cleaning appropriately. We reviewed a selection of syringe pumps and the planned preventive maintenance (PPM) schedule which showed all were tested and in date. This meant equipment required for providing safe care to patients at the end of their life were being serviced and maintained.

The mortuary had accommodation for 104 deceased patients which included bariatric patients. There were an additional 10 spaces available for deceased babies. The mortuary also had an additional 54 temporary spaces available.

The mortuary was accessed via secure swipe access or intercom. Mortuary staff told us the list of persons who had access to the mortuary was reviewed and updated annually.

The service had enough suitable equipment to help them to safely care for patients. The service
had a large stock of syringe pumps which were available to patients to use in the hospital and in the community. This was an improvement since our last visit. Syringe pumps were in line with nationally recognised guidance and were tamper proof.

The mortuary had a cuddle cot. This is a refrigerated Moses basket where a deceased baby could be placed to allow them to stay cool while family spent time with them.

Staff disposed of clinical waste safely. Staff carried out appropriate waste segregation in all the areas we visited. Mortuary staff had completed labels on sharps disposal containers and had not overfilled them.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them appropriately. Nursing staff completed national early warning scores (NEWS) to monitor patient vital signs and identify any deterioration. Patient records showed that nursing staff escalated deteriorating patients to more senior nurses or medical staff appropriately.

Nursing staff monitored and reviewed patients who were at the end of life through intentional care rounding. Intentional care rounding is a process where staff carry out regular checks with individual patients at set intervals. Checks included assessing the patient’s general comfort, symptoms and personal care such as mouth care.

The SPCT held a case load of between five and eight patients each. The consultants held the more complex patient cases. SPCT staff provided continuity of care by ensuring they routinely saw the same patients during their care on the ward.

Staff completed risk assessments for each patient on admission and updated them when necessary and used recognised tools. Ward nursing staff completed nationally approved risk assessments for patients in receipt of end of life care. These included assessments of the risk of pressure ulcers, risk of falling, nutritional risk and moving and handling risk assessments.

Staff knew about and dealt with any specific risk issues. All 15 of the patient medical care records we reviewed evidenced ward staff completed appropriate risk assessments for patients in line with trust guidance.

Staff had documented ceiling levels of treatment in all the relevant patient medical care records we reviewed. This was an improvement since our last visit. Ceilings levels of treatment are often agreed between healthcare teams, and where possible, the patient or family so that if deterioration in the patient’s condition occurs suddenly, all involved in the care of that patient know how to proceed. A ceiling level of treatment could include not escalating the patient to intensive care or not performing resuscitation.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient’s mental health). Staff could access the trust wide mental health team for support 24 hour. SPCT staff told us the team were very responsive.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The SPCT had access to a specialist palliative care
(SPC) nurse psychologist Monday to Friday between 9am and 5pm for any patients who they thought to be at risk.

Staff shared key information to keep patients safe when handing over their care to others. Members of the SPCT updated the nurse in charge (NIC) regarding the patient’s care plan after each visit with their patient. SPCT recorded their visit in the patient’s care record. This ensured information was shared with everyone providing care to the patient.

Shift changes and handovers included all necessary key information to keep patients safe. SPCT staff completed case records after each patient contact. Staff entered these onto an electronic patient record and passed hard copies on to SPC team members along with a verbal handover if they were not available to follow up the patient. This meant all SPCT staff had access to information regarding every patient under the care of the SPCT.

**Nurse staffing**

The service had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough nursing and support staff of relevant grades to keep patients safe. Staffing of the specialist palliative care team (SPCT) consisted of 10 clinical nurse specialists (CNS) in palliative care, including two palliative and end of life care educators and three administrative and clerical support staff.

The SPCT leaders told us that at weekends, when there was no administrative support, they spent a lot of time completing administrative tasks relating to syringe drivers and this took up valuable time which could be spent on providing direct patient care. This was identified as a risk on the SPCT risk register and managers were looking to recruit additional administrator support.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. At the time of our inspection the mortuary was at staffing establishment but, due to changes in demand, the trust was undertaking a staffing review.

SPCT nurses were available in the hospital Monday to Sunday from 9am until 5pm.

The table below shows a summary of the nursing staffing metrics in end of life care at Norfolk and Norwich University Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>End of life care annual staffing metrics</th>
<th>August 2018 to July 2019</th>
<th>July 2018 to June 2019</th>
<th>April to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff group</td>
<td>Annual average establishment</td>
<td>Annual vacancy rate</td>
<td>Annual turnover rate</td>
</tr>
<tr>
<td>Target</td>
<td>10%</td>
<td>10%</td>
<td>3.9%</td>
</tr>
<tr>
<td>All staff</td>
<td>48</td>
<td>10%</td>
<td>13%</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>9</td>
<td>7%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Nurse staffing rates within end of life care were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy and turnover. The trust only provided data on bank use for four months and therefore analysis of change over time was not possible. No agency usage was reported.

**Vacancy rates**

The service had no nursing staff vacancies for nursing staff. The SPCT had recently recruited a palliative care nurse who was a dementia specialist and were now at establishment.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

The service had low turnover rates for nursing staff. The SPCT was a stable team with minimal staff turnover.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

The service had low sickness rates for nursing staff.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

The service had low rates of bank nurse usage and did not use agency staff. Managers limited their use of bank staff and requested staff familiar with the service.
The mortuary and bereavement service consisted of a service manager, four whole time equivalent (WTE) anatomical pathology technicians, two WTE administrative and clerical support and three WTE bereavement advisers. The trust was conducting a staffing review of the mortuary at the time of inspection.

### Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. The Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care states there should be a minimum of one consultant per 250 beds. There were six consultants within the specialist palliative care team covering approximately 951 in-patient beds. This was in line with the guidance.

The table below shows a summary of the medical staffing metrics in end of life care at Norfolk and Norwich University Hospital compared to the trust’s targets, where applicable:

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<tr>
<th>End of life care annual staffing metrics</th>
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<tr>
<td><strong>Staff group</strong></td>
<td><strong>Annual average</strong></td>
<td><strong>Annual vacancy</strong></td>
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</tr>
<tr>
<td><strong>Target</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>48</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Medical staff</td>
<td>17</td>
<td>16%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Medical staffing rates within end of life care were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover and sickness. No locum usage was reported.

SPCT doctors were available in the hospital from Monday to Sunday between 9am and 5pm with an out of hours telephone on call service provided by a palliative care consultant from the local hospice.

### Vacancy rates

The service had low vacancy rates for medical staff. The SPCT had recently recruited an
additional consultant and were now at establishment for medical staff.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

The service had low turnover rates for medical staff.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

The service had low sickness rates for medical staff.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and locum staff usage**

The service had low rates of bank and locum staff. The SPCT did not use locum or agency medical staff.

(Source: Routine Provider Information Request (RPIR) – Medical locum agency tab)

**Records**

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

Patient’s notes were comprehensive, and all staff could access them easily. We reviewed 15 paper-based patient medical and nursing care records. They were organised, legible and contemporaneous.

Records were stored securely. Staff stored the patients’ medical records in notes trolleys beside nursing stations. On all the wards we visited staff had closed the trolleys or were using them. This was an improvement since our last visit. Staff stored patient nursing notes at the patients’ bedside in opaque folders.

SPCT nurses carried information relating to patients in their case load in a closed document wallet to protect confidentiality.

**Medicines**

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The trust used electronic prescribing on all inpatient wards. Medical staff prescribed anticipatory medicines using the electronic prescribing tool.

Of the 15 patient medical records we reviewed, medical staff had prescribed anticipatory medicines in all of them where appropriate. Anticipatory prescribing (medications that are prescribed for use on an "as required" basis to manage common symptoms that can occur at the end of life) followed the NICE guidelines, Care of dying adults in the last days of life (NG31) for symptom control.
Eight patients were receiving medicines through syringe pumps at the time of our inspection. According to trust policy, the syringe pumps should be checked and recorded every four hours. Five patient records showed nursing staff on four wards carried out syringe driver checks in line with trust policy.

Three records evidenced staff had not completed checks appropriately. These all related to patients who were on Mulbarton ward. We escalated this to the ward manager who acted immediately to address our concerns.

The SPCT audit of syringe pumps 2019, looked at 30 syringe drivers across 12 wards. Results showed that symptom monitoring took place every four hours, or six times within 24 hours, in 88% of cases. Managers identified actions to improve syringe driver monitoring.

Between Monday and Friday, during office hours, staff throughout the trust obtained syringe pumps from the SPCT office. Outside these hours staff obtained syringe pumps from the trust operations office.

The SPCT had a grab bag for the emergency department. This contained all the necessary equipment and documents to provide a patient with a syringe pump quickly should the emergency department require it.

Staff reviewed patient’s medicines regularly and provided specific advice to patients and carers about their medicines. Specialist palliative care team nurses reviewed patient medicines at each visit.

Decision making processes were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines. None of the patient medical records we reviewed showed evidence that staff used drugs to control patient behaviour inappropriately.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. All the staff we spoke with knew what type of incident to report and how to do it.

Two members of staff in the mortuary were able to describe changes in procedures which managers had implemented as learning from an incident. For example, using sink liners when sinks were full in order to prevent losing items down the plug during draining.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. The service had systems and processes in place to report incidents and staff told us they were encouraged to do so. Staff reported incidents through the trust’s electronic reporting system.

**Never Events**

The service had no never events on any wards. From October 2018 to September 2019, the trust did not report any never events for end of life care. 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.
Breakdown of serious incidents reported to STEIS

Staff reported serious incidents clearly and in line with trust policy. In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SI) in end of life care which met the reporting criteria set by NHS England from October 2018 to September 2019.

The incident, which occurred in the mortuary, was categorized as an incident affecting a patient’s body after death meeting SI criteria. We spoke with two mortuary staff about this incident. Both were able to describe the new procedures implemented by managers as learning from the incident.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. All the staff we spoke with about duty of candour were aware of the regulation and what would trigger it, although none of them had ever carried it out.

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.

Managers investigated incidents thoroughly and debriefed and supported staff after any serious incident. Incidents relating to end of life care were referred to the End of Life Steering Group for discussion and dissemination. The group met monthly and incidents were a standing agenda item.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care. Clinical governance meeting minutes (21 November 2019, 17 October 2019, 26 September 2019) demonstrated discussions around recent incidents and sharing of learning.

There was evidence that changes had been made as a result of feedback. As a result of an incident in the mortuary, the mortuary manager had arranged for the purchase of new equipment and had introduced a new procedure to avoid a similar incident from occurring.

Safety Thermometer

The service used monitoring results to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The service continually monitored safety performance. Staff collected data on the perfect ward and used it to further improve services. SPCT managers reviewed perfect ward data as part of their monthly clinical governance meetings.
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Staff followed up to date policies which were accessible via the trust wide intranet. We reviewed the Care After Death policy. The policy was comprehensive and up to date. It was due for review January 2021.

Staff assessed people's physical, mental health and social needs holistically, and delivered care, treatment and support in line with legislation, standards and evidence-based guidance, including National Institute for health and Care Excellence (NICE). This was evidenced, where appropriate in all the medical care records we reviewed.

The ‘Individual End of Life Care Plan for Adults’ recognised the five priorities for care according to the Leadership Alliance for the Care of Dying People (2014). The Leadership Alliance for the Care of Dying People promotes a consistent approach to end of life care through five key principles.

The Individual End of Life Care Plan for Adults document guided clinicians through a series of prompts to discuss the patient’s personal and clinical needs, preferences, and the amount of intervention required. It guided clinicians to consider the emotional, psychological and spiritual support needed. All the patient medical care records we reviewed showed details of conversations with the patient and/or family, recognition of dying, symptom control, and assessment of nutrition and hydration needs where appropriate.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. At the time of inspection, no patients were subject to the Mental Health Act, however, staff described how they would provide care for these patients in line with trust policy.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. The specialist palliative care team (SPCT) held daily case meetings at 9am and again at lunchtime. This enabled nurses to share information regarding patients on their case load with the rest of the team and seek any advice needed from consultants. SPCT staff always referred to patients psychological and emotional needs.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Ward staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. At each contact with the patient, SPCT nurses ensured they patient could reach their drinks where appropriate. We observed SPCT nurses making a patient a fresh cup of tea and supporting them to drink it.

Ward staff fully and accurately completed patient’s fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. This was evidenced in all the patient medical records we reviewed.
Specialist support from staff such as dieticians and speech and language therapists was available for patients who needed it. Ward staff sought support and input from allied health staff such as speech and language therapy (SALT) and the diettian. This was evidenced in the medical records we reviewed.

The Individual End of Life Care Plan included a comprehensive list of nutrition and hydration considerations. This included prompts for nutrition and hydration assessment at every review, mouth care, swallowing assessment and respecting the dying person’s choice to eat and drink. Staff we spoke with told us they would be flexible to accommodate the patient’s wishes. One patient told us staff had arranged for them to have cheese and biscuits for their evening meal as that was what they “fancied”.

**Pain relief**

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

Staff assessed patient’s pain and gave pain relief in line with individual needs and best practice. Specialist palliative care team (SPCT) nurses assessed each patient’s pain at each visit and this was clearly documented in all the care records we reviewed.

Where appropriate, patients had syringe pumps, which delivered measured doses of pain relief over 24 hours. In the wards we visited, the qualified nursing staff we spoke with were trained in using syringe pumps and symptom management.

Patients received pain relief soon after requesting it. We spoke with three relatives who told us their loved ones received good pain relief and their pain was under control.

Staff prescribed, administered and recorded pain relief accurately. SPCT documented in the patient care plan and discussed with the ward staff about the prescribing of anticipatory medicines for pain relief.

Anticipatory prescribing (medications that are prescribed for use on an "as required" basis to manage common symptoms that can occur at the end of life) followed the NICE guidelines, Care of dying adults in the last days of life (NG31) for symptom control.

The trust had guidelines for management of pain in the care of a patient in the last days of life. These guidelines were available as flow charts in the wards we visited and also on the intranet so staff had easy access to them.

We reviewed 15 patient medical care records for patients who were considered to be in the last days/weeks of life. All patients were appropriately prescribed anticipatory medicines for their symptoms.

Staff in the wards we visited told us that SPCT consultants and nurses were able to provide guidance on the most effective and appropriate treatments and care at end of life, which included pain relief and management of nausea and vomiting.

**Patient outcomes**

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

The service participated in relevant national clinical audits. The SPCT participated in the national audit of care at the end of life (NACEL) 2019 and in the national Famcare survey October 2019.

Outcomes for patients were positive, consistent and met expectations, such as national standards. NACEL findings from 2019 showed the trust scored better than the national average in all nine areas reviewed. SPCT managers had used the audit findings to develop an action plan to improve further.

The Famcare survey established bereaved relatives’ satisfaction with specialist palliative care services. Famcare survey results for 2018/2019 were not available at the time of our inspection. However, data from the SPCT annual report April 2018 for the period 2017/2018 stated “all results (100 relatives surveyed) in good or excellent category and results comparable to national results”.

SPCT staff used the integrated palliative outcome scale (IPOS) to score patients at each outpatient clinic visit. The IPOS is a way of scoring the most important patient concerns, for example, symptoms, mood, practical concerns and family anxiety. Staff identified that the highest scoring concern at first visit to the clinic was pain, this had reduced in score at the second visit.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The SPCT completed local audits to measure patient outcomes and was on target with the audit plan for the period 2018/2019.

The SPCT audited time to first visit after referral. Audit results 2019 showed 89% of patients referred for symptom control were seen within 24 hours (target 90%) and 94% of patients were seen within 48 hours (target 90%).

The SPCT audit of preferred place of care (PPC) September 2019, evidenced that out of 195 patient medical records reviewed, 67% had a clear PPC recorded and of those 78% achieved their PPC before they died. This was an improvement on the PPC audit of September 2017 where only 31% of patients reached their PPC before they died.

The SPCT audit of syringe pumps 2019, looked at 30 syringe pumps across 12 wards. Results showed that symptom monitoring took place every four hours, or six times within 24 hours, in 88% of cases. This was a slight improvement on the audit findings of March/April 2018 where symptom monitoring took place every four hours, or six times within 24 hours, in 86% of cases.

Managers and staff used audit results to improve patient outcomes. Managers had identified actions to improve syringe pump monitoring compliance by targeting training to specific wards and individuals.

Managers shared and made sure staff understood information from the audits. Audit outcomes and action plans were shared by the service manager at clinical governance meetings (21 November 2019, 17 October 2019, 26 September 2019) and by the Specialist palliative care annual multidisciplinary team (MDT) report

Improvement was checked and monitored. The SPCT audit schedule for 218/219 evidenced audits were repeated throughout the year in order to monitor any changes in processes that they had implemented and check for service improvement. For example, the preferred place of care audit (PPC) was performed weekly along with the four hourly syringe pump checks.
**Competent staff**

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. All the SPCT staff had completed their syringe pump competency. One SPC nurse was a nurse prescriber.

SPCT staff performed a syringe pump audit 2019. They reviewed the syringe pumps of 30 patients across 12 wards and identified 70% of all nurses had completed their syringe pump training. SPCT managers identified the need to continue to train ward-based nurses on syringe pump competency.

In October 2019, SPCT managers introduced train the trainer regarding syringe pumps for each ward. Ward nurses received syringe pump training and completed a self-assessment of their competency. A SPC clinical educator signed off each competency and forwarded it to the electronic staff record (ESR). This meant that when ward managers were planning shift rotas they could ensure that there were always nurses competent in the use of syringe pumps available.

Managers gave all new staff a full induction tailored to their role before they started work. Two of the SPCT staff were clinical educators and they spent time providing end of life care training to all new starters at their induction and ongoing training to ward based staff.

SPCT managers were developing an end of life (EoL) care training passport to enable staff to keep a record of all training received and competencies developed in the specialism of EoL care.

**Appraisal rates**

From April 2018 to March 2019, 85.7% of staff within end of life care department at Norfolk and Norwich University Hospital received an appraisal compared to the trust target of 85%.

Data supplied by the trust showed 100% of specialist palliative care team (SPCT) were up to date with their annual appraisal.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Additional professional, scientific and technical</td>
<td>7</td>
</tr>
<tr>
<td>Healthcare scientists</td>
<td>3</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>9</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. SPC nurses had formal supervision once every four weeks and completed a reflective practice of a patient monthly. Staff told us they could access support and guidance twice daily or
more as they shared an office and met with SPC consultants at least twice daily. Two SPC nurses told us that the weekly ward round with the SPC consultant was a good learning opportunity and that it was valuable for individual development.

The clinical educators supported the learning and development needs of staff. The two SPCT clinical educators spent time on the wards delivering face to face bite size training and updates to all staff of all grades. Training including syringe pumps, basic symptom control and role modelling for communication skills. Two ward nurses told us these short sessions were very useful and informative but did not impact on nursing time too much. Another nurse said, “I always think back to my “comms” (communication) training when speaking to the family of patients receiving end of life care”.

The SPCT delivered a three-hour workshop on communication skills for junior doctors through role play. The workshop taught the communication skills required to: notice distress, hear the concerns that a person may have, and respond helpfully to them.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Three SPC nurses we spoke with told us they had completed their appraisal and it had been useful. Managers had supported them to identify additional training needs and supported them to develop.

The trust recruited, trained and supported volunteers to support patients in the service. The trust had 15 Butterfly volunteers who provide companionship and company to patients who are recognised as being in the last days and hours of their lives.

All the wards we visited had palliative/end of life care link nurses who assisted with training and information sharing on the ward.

**Multidisciplinary working**

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The SPCT held weekly multidisciplinary team meetings (MDT). Medical and nursing staff discussed each patient under the care of the SPCT in turn. Discussions were holistic.

Ward staff we spoke with knew how to contact the specialist palliative care team (SPCT) and were positive about the input and care delivered by them.

All the patient medical care records we reviewed evidenced a strong culture of MDT working. Different services identified their entries in the patient medical notes by using different coloured stickers. This evidenced all the necessary staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment to patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. SPCT staff had access to the trust wide mental health team and knew how to refer patients to them if they had concerns over their mental wellbeing.

SPCT consultants attended MDT meetings for their speciality, for example cardiology and motor neurones disease (MND). This ensured that the palliative and end of life aspects of care were also considered for each patient discussed at the meeting.

We witnessed two SPC consultants liaising with the hospital diagnostic imaging department in order to arrange a scan for a patient who was receiving palliative care and would need specialist pain management during the procedure.
The SPCT were able to refer families to family therapy service provided by the local hospice. Staff gave numerous examples of when this had happened.

**Seven-day services**

**Key services were available seven days a week to support timely patient care.**

The specialist palliative care team (SPCT) nurses and consultants, were available seven days each week from 9am until 5pm. The local hospice provided an out of hours consultant led telephone advice line between 5pm and 9am. This was by way of a service level agreement. This was an improvement since our last visit.

The mortuary staff were on site during the day Monday to Friday and had an on-call rota for staff out of hours.

Chaplains of all denominations could be contacted to provide holistic support to patients and families 24-hours a day seven days per week.

Each SPC consultant completed a weekly round following a different SPC nurse. This ensured each consultant had a good understanding of each patient receiving SPC and that each patient had been reviewed by an SPC consultant.

**Health Promotion**

**Staff gave patients practical support to help them live well until they died.**

The service had relevant information promoting healthy lifestyles and support on the wards/units. Ward staff displayed leaflets on subjects such as eating a healthy diet and smoking cessation.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff offered patients advice and support at the breathlessness clinic.

Staff could access the trust wide mental health team and the substance abuse service to support patients living with those issues. The SPCT also had access to an SPCT psychologist to provide psychological support to patients and their families.

The SPCT ran a stall during the Dying Matters week. Dying Matters is a coalition of individual and organisational members across England and Wales, which aims to help people talk more openly about dying, death and bereavement, and to make plans for the end of life.

**Consent, Mental Capacity Act and Deprivation of Liberty safeguards**

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

Staff gained consent from patients for their care and treatment in line with legislation and guidance. SPCT staff obtained verbal consent from patients at each visit.

Staff clearly recorded consent in the patients’ records. All 15 patient medical care records we reviewed evidenced staff had sought verbal consent from patients.

When patients could not give consent, staff made decisions in their best interest, taking into account the patient’s wishes, culture and traditions. All the staff we spoke with knew how to
assess patient mental capacity and could describe how they would support patients to make a decision if appropriate.

We reviewed seven do not attempt cardio pulmonary resuscitation (DNACPR). The seven DNACPR records we reviewed were all completed in line with Resuscitation Council UK guidelines. This was an improvement since our last visit. DNACPR documents recorded involvement of family, and patients where appropriate, and whether or not the patient had capacity to consent.

The SPCT conducted a trust-wide DNACPR audit (September 2019) which they reported “good documentation” but planned to introduce trust wide action to improve compliance further.

**Mental Capacity Act and Deprivation of Liberty Safeguards training completion**

Nursing and clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was part of staff's mandatory training for staff band five and above. Staff we spoke with were able to describe the process they would follow should someone be found to not have capacity to agree to treatment or be able to make decisions in relation to their care.

**Norfolk and Norwich University Hospital**

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training. The trust provides end of life care services at Norfolk and Norwich University Hospital only.

A breakdown of compliance for MCA/DoLS training courses from August 2018 to July 2019 at Norfolk and Norwich University Hospital for qualified nursing staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act level 2</td>
<td>10</td>
</tr>
<tr>
<td>Deprivation of liberty safeguards</td>
<td>10</td>
</tr>
</tbody>
</table>

In end of life care the target was met for both MCA/DoLS training modules for which qualified nursing staff were eligible.

A breakdown of compliance for MCA/DoLS training courses from August 2018 to July 2019 at Norfolk and Norwich University Hospital for medical staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
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<td>11</td>
</tr>
<tr>
<td>Deprivation of Liberty Safeguards</td>
<td>11</td>
</tr>
</tbody>
</table>

In end of life care the target was not met for either of the MCA/DoLS training modules for which medical staff were eligible.
Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice (AMSAT). All the staff we spoke with knew how to assess patient mental capacity and could describe how they would make a best interest decision if appropriate.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. MCA and DoLS guidance was available on the trust’s intranet and associated documents such as the consent policy, dementia policy and safeguarding adults at risk policy.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. The trust wide audit of MCA (September 2019) demonstrated “poor compliance” with MCA documentation. The SPCT had developed a trust wide action plan to address compliance.

Staff had completed mental capacity assessments in the six relevant patient medical care records we reviewed where staff identified concerns around patient capacity.

Staff implemented DoL safeguards in line with approved documentation. At the time of our inspection, staff were not using DoLS for any patients receiving palliative or end of life care. Staff could describe procedures and policies they would follow.
Is the service caring?

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. All staff members introduced themselves to the patient and family every time they visited them.

Staff drew curtains around bed spaces or closed side room doors when speaking to patients and their families to protect privacy and dignity.

Porters covered deceased patients while they transported them from the ward to the mortuary on a hospital trolley to protect their privacy and dignity. Porters collected small children from the ward in a pram and small babies in a concealment box.

Porters and mortuary staff said that deceased patients were handled in a compassionate way.

Mortuary staff dressed deceased babies in knitted gowns for families to view them. They placed tiny babies in miniature knitted Moses baskets. Families could take the gown or basket away with them afterwards.

When preparing a body to go to the mortuary, nursing staff spoke kindly to the patient; explaining what they were doing.

Bereavement office staff gave patient belongings to family members in a private room when families came to collect the relative’s medical care certificate.

Patients said staff treated them well and with kindness. We spoke with seven patients and three relatives. Everyone spoke very highly of the specialist palliative care team (SPCT) telling us they were “a breath of fresh air” and that they always had time to listen and they were kind.

Staff followed policy to keep patient care and treatment confidential. Staff ensured computer screens were locked and patient information was not visible on papers when they left workstations.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. During the weekly multidisciplinary team (MDT) meeting held between SPCT nurses, consultants and doctors staff discussed patients holistically and had a good understanding of their social circumstances. For example, staff discussed transferring a patient to the local hospice and said that if it could be done quickly then the patient, who had been missing their dog, could be reunited with it sooner. Another patient had a partner who had poor mobility. Staff were trying to arrange transport for the relative to visit the patient as the patient had been in a low mood due to being unable to see them.

SPCT staff described a situation where a patient who was identified as being at the end of life was brought to the emergency department. The patient was deeply concerned that there was no one at home to care for their dog. The SPCT nurse arranged with the patient’s next of kin and a local charity to have the dog collected and brought to the hospital so the patient could see it was being cared for.

The mortuary was able to accommodate the spiritual and cultural wishes of all faiths and none. For example, enabling families of Muslim patients to wash their deceased relative’s

Staff had a deep understanding of their patients. For example, they knew if the patient could only
hear in one ear, or if they could only listen for a short period of time and they used this information to communicate appropriately with them. For example, getting close to the patient’s ear or prioritising what order to ask questions or share information.

Staff shared medical information with friends of patients, when there was no next of kin, where the patient had requested they do so.

Staff described how one EoL patient from the traveller community had four family members staying with them to enable them to be surrounded by family at the end of life was part of the traveller culture.

**Emotional support**

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

Throughout our inspection, we observed staff treated patients with compassion, dignity and respect. Medical and nursing staff we spoke with were aware of the importance of treating patients and their visitors in a sensitive manner. All staff we spoke with had a genuine desire to want to provide the best possible care for patients at the end of life.

Chaplaincy, bereavement and mortuary staff were passionate and committed to ensuring the deceased were cared for with compassion and respect, both before and after death.

Staff gave patients and those close to them help, emotional support and advice when they needed it. The Chaplaincy service provided spiritual and emotional support for staff, patients and families of all faiths or none.

Once a patient had been identified as end of life, the Chaplaincy service received an electronic alert and the patient name was identified in colour on their screen. This enabled Chaplains to prioritise their visits more appropriately and ensure they visited the patient when the family may be present to offer support to them too.

The trust operated the Butterfly volunteer scheme. The scheme aims to provides company to patients who have no other visitors with the goal of making sure that no patient dies alone. The trust has 15 Butterfly volunteers who provide companionship and company to patients who are recognised as being in the last days and hours of their lives.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Wherever possible, and if it was the wish of the patient, nursing staff cared for patients who were at the end of their life in side rooms to protect the privacy and dignity of the dying patient and their families.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. The SPCT delivered training to all staff around communicating difficult conversations. One nurse we spoke with described how they always drew upon their training when speaking to patients and their family.

Patient nursing notes we reviewed evidenced that staff held difficult conversations with patients and their families.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. The SPCT considered the wellbeing of patients’ families. We heard the SPCT nurses and consultants planning how to transport a frail family member from their home to spend time with their relative who was receiving end of life care.
Members of the SPCT had decorated an end of life (EoL) care patient’s room so that the family could have early Christmas celebrations together. A family member told us staff had enabled them to bring in a small amount of alcohol for their relative during the celebration.

One ward nurse described how they had been involved in arranging an early pregnancy scan so that a family member who was receiving EoL care could see the unborn baby before they died.

A SPC nurse described how a patient had wanted to visit their home village again before they died but had been too unwell to do so. The nurse had bought the patient a book with photographs of the village and spent time reminiscing with them about their time there.

The SPCT described how they arranged with a charity to bring an EoL care patient’s dog to the hospital because the patient was desperate to say goodbye to them before they died.

Staff described how a patient receiving end of life care had requested they used the duvet cover of a family member, so they felt close to each other. This request was fulfilled.

SPC staff described how they had supported end of life patients to arrange weddings and usually supplied the cake and had a tiara in the cupboard to lend to the bride.

Mortuary staff created memory boxes for families of deceased babies and children. These contain things such as hand and foot prints and locks of hair among other things which the family may wish to include.

SPCT staff sent bereavement cards to recently bereaved relatives and telephoned them to offer support and signposting to bereavement services.

SPCT staff gave examples of going above and beyond for patients receiving their care, for example, supplying cards for patients to send to relatives on special occasions; organising to take poorly patients to other wards to see family members; arranging for electrical equipment to undergo portable appliance testing to allow patients to use them while in hospital.

Results from the national audit of care at the end of life (NACEL) 2019 showed meeting the needs of families and others scored 8 which was better than the national average of 6.1.

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

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

Staff made sure patients and those close to them understood their care and treatment. All staff we spoke with had received communication training delivered by the SPCT. Staff answered patients’ questions clearly and honestly using sensitive language. In some of the medical care records we reviewed staff had documented that they had tried to discuss a difficult topic with the patient but the patient had not wanted to discuss it at that time. Notes clearly evidenced staff had revisited the topic on further occasions.

Patients were active partners in their care. Nursing staff really listened to the wishes of their patients and advocated for them. SPC nurses sat at the same level as patients whilst talking to them and ensured that the patient’s priorities were the priorities for their care going forward. For example, one patient was due to be discharged home and their family was excited to receive them. However, the patient did not want to go home but wanted to go to a nursing home. The SPCT nurse liaised with the family to ensure the patient’s wishes were met.
Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. All the patient medical records we reviewed evidenced staff had held in depth conversations with relatives about their family member’s condition. Some records included the length of time the conversation had lasted, and staff had recorded the relative’s feelings and views.

Staff could access a hearing loop, and a translation service for those patients who did not speak English as a first language and use British Sign Language (BSL) for those patients who required it.

Staff supported patients to make advance decisions about their care. Patient medical records evidenced staff approached the subject of end of life care planning tactfully and often revisited it over a number of days to ensure the patient had a clear understanding of the decisions they were making and had time to reflect on them.

Staff talked through a leaflet called Cardiopulmonary Resuscitation (CPR) with patients who had questions about CPR. The leaflet was in simple language and described advantages and disadvantages of CPR. It provided a starting point for conversations between patients, their families and staff about advance care decisions.

The SPCT team had developed a selection of information leaflets which staff gave to patients and their relatives. Leaflets included information on; syringe pumps, starting opioid medicines, frequently asked questions, pain relief patches, advanced care planning and travelling abroad among other things.

Staff supported patients to make informed decisions about their care. Entries in the patient record, written by SPCT staff clearly recorded conversations between SPCT staff and patients and their relatives.

Patients gave positive feedback about the service. We spoke with seven patients and three relatives during the inspection. The patients and relatives were consistently complementary about staff attitude and engagement.

During the inspection, members of the SPCT received gifts and cards from the family of a deceased patient as a thank you for the care they had provided.

Staff in the SPCT received many thank you cards. One card praised them for “the excellent holistic care”, another said “staff went above and beyond offering medical care and provided kindness”.

Relatives confirmed there was open visiting. Staff told us they would offer relatives to stay over if they wished to do so and would organise foldaway beds if the patient was in a side room.

Relatives confirmed staff supported them to stay overnight as comfortably as possible and the trust had arrangements in place to facilitate this.

Staff gave relatives of patients who were receiving EoL care a booklet called a carers passport. This entitled relatives to free car parking and discounted meals in the restaurant.

Bereavement administrators went to great lengths to identify family or friends of those patients who had died at the hospital but had no known next of kin before making funeral arrangements. One administrator described how using an advert in local newspaper and contacting ex-serviceman groups had reunited an estranged family member with a deceased relative.

Staff could give examples of how they used patient feedback to improve the quality of care they
provided. Staff described how they were mindful of the language they used when speaking to relatives of deceased patients in order not to appear insensitive. This was as a result of feedback from a deceased patient’s family.

Results from the national audit of care at the end of life (NACEL) 2019 showed communication with the dying patient scored 8.4 which was better than the national average of 6.9 and communication with relatives and family scored 8.1 which was also better than the national average of 6.6. NACEL audit results for involvement in decision making scored 8.9 which was better than the national average of 8.4.
Is the service responsive?

Service delivery to meet the needs of the local people

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

Managers planned and organised services, so they met the needs of the local population. The specialist palliative care team (SPCT) worked collaboratively across the locality with the clinical lead attending the Palliative and End of Life Care Collaborative Group. This group met on a bimonthly basis and had representation from the clinical commissioning groups (CCGs), local hospice, county council and ambulance service. As part of this collaborative work, the community services had adopted the trust’s individualised care plan.

SPCT managers had developed an end of life care bundle for any patients who attended the emergency department (ED) and were identified as being end of life. The SPCT aimed to attend the ED within 30 minutes of referral, set up the syringe pump and begin the process of prescribing anticipatory medicines.

The SPCT provided a rapid response service, via a dedicated telephone number, for the emergency department (ED) and critical care. This meant any ED patient who was identified as being at end of life (EoL), needing specialist palliative care or who had deteriorated in critical care would be seen by an SPCT consultant within half an hour.

The trust had a system in place to highlight patients who were at the end of their lives. Patients who were at the end of their life had a blue border around their bed space on the electronic ward system for ease of identification and discussion at board round. This was in use during our inspection.

Ward staff used a pink border around the patient name on an electronic white board to enable ease of identification of those patients who were receiving care from the SPCT.

Relatives visiting the bereavement office to collect the patient’s medical care certificate could visit the registrar at the same time. This meant that relatives could register their loved one’s death and collect their death certificate in one place.

Mortuary visiting could be arranged out of normal office hours and at weekends. The viewing room in the mortuary was a neutrally decorated space with simple furnishing where family could come to spend time with their deceased relative.

The Multi faith room was open 24 hours a day, seven days a week to enable people of all faiths or none to have a calm, quiet space to sit. There was a separate Muslim prayer room with washing facilities and prayer mats.

The SPCT provided outpatient clinics in three different locations, one at the hospital, one in Beccles and one in Cromer to reduce the travelling distance for patients using the service.

Facilities and premises were appropriate for the services being delivered. Where it was possible, and it was the wish of the patient, nursing staff cared for patients receiving end of life care in side rooms.

Staff could access emergency mental health support 24 hours a day seven days a week for patients with mental health problems, learning disabilities and dementia. The SPCT had recently
appointed a SPC nurse who had additional expertise around supporting patients in receipt of palliative care who were living with dementia.

The service relieved pressure on other departments when they could treat patients in a day. The specialist palliative care team offered 10 outpatient clinics per week to support patients receiving palliative care in the community with symptom management, this avoided patients being admitted to hospital.

The service had suitable facilities to meet the needs of patient’s families. All staff provided families with fold away beds, so they were able to stay with their relatives overnight if the patient was end of life. Staff allowed families to use patient bathroom facilities where patients were being cared for in side rooms.

The hospital had a multifaith room and a chapel, which meant patients and families of all faiths or none had somewhere restful, calm and quiet to spend time away from the bedside.

**Meeting people’s individual needs**

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The SPCT had recently recruited an SPC nurse with a specialism in supporting patients living with dementia.

The trust had trained 140 nurses as dementia champions across all appropriate wards within the hospital.

The SPCT had twenty-four-hour access to the trust wide mental health support team.

Staff told us they supported patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports. None of the patient records we reviewed related to a patient living with dementia or a learning disability. Staff knew they could access these documents through the trust’s intranet site.

Managers made sure staff, patients and their loved ones and carers could get help from interpreters or signers when needed. Staff told us they had access to face to face interpreters, language line and British sign language (BSL) and had used these services in the past successfully.

All the wards we visited had access to a hearing loop for those patients who had hearing difficulties.

All wards had access to equipment suitable to provide care for those patients who were obese. For example, hoists, beds and other equipment.

The Chaplaincy service received an electronic alert when those patients who had previously used the service were readmitted to the hospital. This meant Chaplaincy staff could visit the patient and offer support before the patient had to ask.

The Chaplaincy service met with the families of babies aged 13 weeks gestation or over who died at the trust as a result of miscarriage. The trust arranged, and funded, the communal burial of every baby who died as a result of a termination of pregnancy.
Access and flow

Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. All medical and nursing staff throughout the trust could refer patients to the SPCT through the electronic referral system. Staff aimed to visit all patients within a 24-hour period.

The SPCT provided a rapid response service to the emergency department (ED) and critical care, staff had a dedicated telephone number to call and an SPCT consultant would attend within half an hour.

Patients recognised as being at end of life were recorded on the ward whiteboard with a blue square around their bed number. The SPCT were able to identify patients recognised as being at the end of their life from the whiteboard on a daily basis. This enabled the SPCT to support the ward nurses, even if the patient did not require specialist palliative care.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. SPCT leaders undertook regular audits to monitor response times to first visit. Audit results April 2019 to December 2019) showed 93% of patients referred to the SPCT were seen within 24 hours (target 90%) and 99% of patients were seen within 48 hours. All the patient medical records we reviewed showed all patients referred to the SPCT had been seen well within the 24-hour time window. Most of them had been seen within the same shift.

SPCT staff used the integrated palliative outcome scale (IPOS) to score patients at each visit. The IPOS is a way of scoring the most important patient concerns, for example, symptoms, mood, practical concerns and family anxiety. Any patient who scored greater than four at discharge was automatically offered an appointment at the outpatient clinics.

Managers and staff worked to make sure that they started discharge planning as early as possible. The SPC discharge team was available to support the SPCT with patient discharges Monday to Friday from 9am until 5pm and one day at the weekend.

Dunston ward (acute stroke unit) had a resident physiotherapist, occupational therapist and speech and language therapist to assist in rapid discharge planning for patients at end of life.

The trust held a tracker which provided them with various data points such as number of referrals, average days of admission to referral, average days of referral to discharge.

We reviewed the tracker (February 2018 to 30 December 2019). In December 2019, the average time for referral to discharge was five days and seven out of 31 patients referred for discharge died before discharge. This showed an improving trend on September, October and November 2019, where 20, 25 and 26 patients respectively had died before fast track discharge.

Staff told us that the fast track discharge process worked well and that they had not had patients delayed from being discharged to their preferred place of death due to the process. Any delays in discharge were usually due to families changing their minds and lack of availability of community palliative beds.

Staff supported patients when they were referred or transferred between services. All the wards
we visited had a dedicated discharge coordinator who attended daily handover and supported in patient discharges.

The SPCT managers had developed a patient pathway to ensure smooth patient handover for all patients about to be discharged from critical care to a ward.

The SPCT supported patients during discharge by transferring care to the community palliative care team and the district nurse via an electronic referral. The SPCT generated a community drug chart, including anticipatory medicines and communicated this to the patient’s general practitioner (GP) along with a paper summary of care given to the patient.

The SPCT was responsible for admitting inpatients to the local hospice. This ensured the sickest patients were given priority for admission to the service when being discharged from the hospital.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. All the relatives we spoke with told us they would know how to raise a complaint if they felt the need to.

The service clearly displayed information about how to raise a concern in patient areas. Ward staff displayed leaflets from the Patient Advice and Liaison service (PALS) which provided information about making a complaint and the relevant contact details.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with about complaints were aware of the policy and described how they would attempt to address the complaint at the bedside and avoid it needing to be escalated.

One SPCT nurse described how they had addressed a complaint from the family. We spoke with the family who told us they were pleased with the outcome.

Summary of complaints

From August 2018 to July 2019 the trust received 14 complaints in relation to end of life care at Norfolk and Norwich University Hospital (1.3% of the total complaints received by the trust).

The trust took an average of 29.5 working days to investigate and close complaints. The trust’s complaints policy states that complaints should be investigated and closed as agreed with the complainant. All complaints had been closed at the time of reporting.

A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communications</td>
<td>5</td>
<td>35.7%</td>
</tr>
<tr>
<td>End of life care</td>
<td>5</td>
<td>35.7%</td>
</tr>
<tr>
<td>Patient care including nutrition/hydration</td>
<td>2</td>
<td>14.3%</td>
</tr>
<tr>
<td>Admission, discharge and transfers</td>
<td>1</td>
<td>7.1%</td>
</tr>
<tr>
<td>Clinical treatment - surgical</td>
<td>1</td>
<td>7.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>
Managers investigated complaints, identified themes and shared feedback from complaints with staff and learning was used to improve the service. SPCT managers discussed complaints with team members as a standing agenda item in the clinical governance monthly meeting. We were able to see from the meeting minutes dated November 2019, recent complaints concerning EoL care were discussed and key learning points shared.

**Number of compliments made to the trust**

From August 2018 to July 2019 there were 54 compliments about end of life care at Norfolk and Norwich University Hospital. Forty-four of these related to the chaplaincy team, nine related to care received at the palliative care clinic and the remaining compliment related to the mortuary.

Since January 2019, the trust aimed to improve collection and recording of compliments. Compliments are reported monthly to the Patient Engagement and Experience Group (PEEG) and there is a monthly analysis of themes. Divisions can access their data for use at local level and for sharing and learning from compliments. Trust wide themes are identified to show how important care, kindness and staff attitude are to the positive experience of patients. Dignity is a key positive theme. A selection of compliments is shared, and individual wards and areas display and share compliments amongst teams.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)
Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The specialist palliative care team (SPCT) was led by a SPC lead consultant and a SPC lead nurse who were both experienced in palliative care. Ward staff and SPCT staff told us both the leaders were visible and approachable and were active members of the SPCT. Leaders held their own patient caseloads. and were active members of the SPCT.

The palliative care consultant and palliative care nurses demonstrated good leadership in the clinical areas, and staff we spoke with on the wards knew who they were and were happy to approach them for advice.

The SPCT led on the delivery of end of life (EoL) care on the wards supported by EoL care link nurses. Staff reported good working relationships with them and were positive about the support and training they provided.

Since February 2018, the SPCT became a new palliative medicine directorate which was part of the trust's medicine subdivision two and was therefore represented on the trust board.

The trust board member with EoL care responsibilities was the director of nursing for the trust so they understood the EoL care issues. The non-executive director (NED) who oversaw EoL care at the trust took an active role and chaired the quality and safety committee and was a member of the audit committee. This was an improvement since our last visit.

Vision and strategy

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

At the time of inspection, the SPCT was coming to the end of their current 12-month plan. The SPCT leaders had a clear vision in the form of a five-year plan (2020-2024) and this was specific to the EoL service and distinct from the overall organisational strategy and vision. The five-year palliative and end of life care education strategy reflected the whole spectrum of EoL care and included conditions other than cancer for example motor neurone disease (MND).

The SPCT leaders developed the strategy in collaboration with staff and external partners, such as the local hospice, and the strategy was due to be launched at the whole team away day in Spring 2020. The strategy evidenced the leaders had taken into consideration findings from previous inspections.

All the SPCT staff we spoke with were aware of the strategy, even though it had not yet formally launched, and were excited to get it underway. The SPCT leaders planned to use monthly performance dashboards to monitor progress against delivery of their targets.
The trust’s End of Life Steering Group met monthly and was accountable to the Patient Experience and Engagement Group (PEEG) formally known as the Caring and Patient Experience (CAPE) Board to deliver palliative and end of life strategies.

Culture

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

All the staff we spoke with were aware of the trust’s freedom to speak up guardian although they said they had never needed to seek their service.

All the SPCT staff we spoke with described the culture within the SPCT as positive and supportive and told us they were proud of the team and the service it offered.

The culture of the SPC team was open and honest, and staff had a good understanding of the Duty of Candour regulation. We heard staff of all grades seeking advice and raising concerns with other SPCT members to obtain the best outcome for patients.

SPCT staff were proud of the care they were able to give and the number of patients they were able to provide specialist palliative care to. There was positive feedback from ward nursing and care staff about the level of support they received from the SPCT.

The mortuary team and bereavement team spoke passionately about improving the care of the deceased patient and their relatives.

Governance

Leaders operated effective governance processes, throughout the service. Staff at all levels had regular opportunities to meet, discuss and learn from the performance of the service.

Palliative and end of life (EoL) care services operated throughout the trust on all wards. Governance of the services sat within the division of medicine. This was led by a divisional director and head of nursing. All the meeting minutes reviewed demonstrated a clear two-way pathway for communication between SPCT staff, the divisional board and the trust board.

The SPCT reported to the end of life (EoL) care steering group which met monthly; the patient engagement and experience board; and the divisional sub board which reported to the trust board.

The monthly clinical governance meeting was chaired by a SPC consultant. Minutes dated 21 November 2019 and 17 October 2019 and 26 September 2019 demonstrated the SPCT managers had oversight of incidents, complaints and risks.

The SPC clinical lead attended the daily serious incident group meeting which was chaired by a member of the executive team. This ensured daily real time feedback of any serious incidents which had happened in the hospital.

Medical division 2 Sub board meeting minutes (October 2019, November 2019, December 2019) demonstrated that staff raised issues discussed at monthly clinical governance meetings and these were further escalated to divisional board meetings.
Board meeting minutes May 2019 evidenced board awareness of EoL care provision throughout the hospital by the sharing of a patient story from the relatives of a recently deceased patient.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

The SPCT held its own risk register for end of life care services. Managers reviewed the risk register on a monthly basis at the clinical governance meetings. This was seen in meeting minutes dated 21 November 2019 and 17 October 2019 and 26 September 2019. Managers escalated serious risks to the divisional governance meeting where they could be entered on the divisional risk register.

SPCT managers told us syringe pumps still remained as an item on the risk register as managers were concerned that managing the syringe pump stock was a full-time administration role and at the time of inspection the SPCT had a part time staff member and used the nurses to undertake the role.

The mortuary service had a policy on how to respond in the event of a major disaster and was able to increase the amount of storage space for patients if needed.

The mortuary had its own risk register. All risks had documented mitigating actions, named risk owners and review dates.

SPCT managers developed an annual audit plan to monitor quality of services. Audit outcomes were reviewed at clinical governance meetings monthly.

SPCT managers reviewed the end of life care dashboard monthly to monitor quality and ensure they were meeting their key performance indicators.

SPCT managers discussed audits and action plans at each monthly clinical governance meeting. This was seen in meeting minutes dated 21 November 2019 and 17 October 2019 and 26 September 2019.

Information management

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

Staff across the trust could access information from the trust’s intranet, such as policies and national guidance.

In the wards that we visited, staff were able to demonstrate that they could easily access information on palliative/end of life care from the intranet. Information included the referral process for the SPCT.

There was a ‘quick link’ on the intranet home page for staff to access the palliative care pages, containing information on end of life care. Staff spoke positively about the SPCT and the ease of accessing information.

SPCT managers spent a proportionate amount of time focussing on quality and sustainability at
monthly clinical governance meetings. This was seen in meeting minutes dated 21 November 2019 and 17 October 2019 and 26 September 2019.

The SPCT had clear and robust service performance measures, which were reported and monitored both monthly and at the annual MDT review.

The trust consistently submitted data to external organisations such as the Somerset cancer register (SCR), the national audit of care at the end of life (NACEL) audit and Famcare. The SCR is a software application developed by the NHS, designed to collect relevant data throughout the patient's cancer journey.

**Engagement**

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

The SPCT carried out a survey of patients and the local community to identify why there was low uptake of outpatient clinics. The survey identified that the patients did not like the clinic names and so were reluctant to attend. The SPCT asked the patients to choose a new name for the clinics. Service managers renamed the clinics and promoted them, and the patient attendance increased. The SPCT had to increase the number of clinics from five to 10 per week as a result.

SPCT staff had used social media to ask the local community to sew small fabric bags so that patients could carry their syringe pumps in them safely. The initiative had been very well supported.

The bereavement team took part in the national Famcare survey. The Famcare survey established bereaved relatives’ satisfaction with specialist palliative care services.

The trust produced a quarterly magazine called the Pulse. The magazine reported on all aspects of hospital activity. The December 2019 was a special edition and was dedicated to staff awards.

The SPCT had won a Pride award for service to the hospital in 2018 and an award for “going above and Beyond” in 2017. This had been recognised by a certificate presented by the director of work force and some cake. SPCT staff told us they had felt values and appreciated.

**Learning, continuous improvement and innovation**

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

The mortuary manager was passionate about introducing care after death ambassadors to each ward. These staff would ensure deceased patients were correctly prepared for the mortuary and that all their possessions were present and correct. The mortuary manager was looking to roll out training in Spring 2020.

The mortuary was planning to expand to allow for an additional substantive 179 storage spaces.

The mortuary manager was researching the possibility of introducing computerised tomography (CT) post mortems. This is a non-invasive procedure where the body is passed through a CT scanner and the scans interpreted by a consultant radiologist who can then determine the cause of death. This would also mean scans can be interpreted remotely which would speed up the post mortem procedure.
The trust was providing patient representative training to a group of relatives of patients who had received palliative or end of life care at the trust with the aim of recruiting some of them to the end of life steering group.

At the time of inspection, the SPCT were working with community groups to improve end of life and palliative care provision in the community for homeless people.

The SPCT was preparing to roll out (March 2020) the Recommended Summary Plan for Emergency Treatment and Care (ReSPECT) which aims to allow clinicians to record a summary of discussions with patients about how they want to be treated in an emergency and at the end of their life. This is to ensure patients are given the opportunity to discuss their preferences and goals for the end of life.
**Outpatients**

**Facts and data about this service**

Outpatients services are provided at Norfolk and Norwich University Hospital (NNUH), Cromer Hospital and at a number of community locations across the local area.

At NNUH there is no central outpatient department; services are provided under the leadership of each clinical division in a number of physical locations across the site. This includes:

- Medical outpatients;
- Ear, nose and throat (ENT);
- Ophthalmology clinic;
- Surgical outpatients;
- Cardiology;
- Plastics;
- Colney Centre breast imaging.

The outpatient booking call centre is based in offices across the city at Rouen Road.

The trust has an outpatients forum which has a focus on staff engagement and is led by four senior outpatient sisters. The aim of the forum is to spread best practice across the trust’s outpatient services and is integral to service improvement.

The trust has launched an outpatient transformation programme with a remit to ensure consistency in respect of outpatient quality standards. The programme will explore options to move to digital solutions for outpatients via a large-scale change process involving patients, clinicians and a wide range of clinical and non-clinical stakeholders across the local health system. The trust also participates in the national NHS benchmarking network.

A regular quality audit tool is in development and there are plans to review and transform some of the basic outpatient processes such as standardised appointment letters to meet information access standards.

The physiotherapy service provides classes such as cardiac rehabilitation and vascular exercise classes as well as specialist musculo-skeletal, women’s health, facial nerve palsy, plastics and hand therapy.

Rheumatology, neurology, pain management services, and respiratory outpatient services are held mainly onsite but also at community centres.

A specialist occupational therapy service assesses and treats patients referred from rheumatology consultants and general practitioners that require specialist input.

The hand therapy service is an integrated service across occupational therapy and physiotherapy, providing assessment and treatment of patients referred from hand surgeons and other plastic and orthopaedic consultants.

A specialist occupational therapy pain management service is provided as part of the trust pain management service. Occupational therapists also provide a pre-operative education and assessment service to elective hip and knee replacement patients, as part of the hip and knee school.
Total number of first and follow up appointments compared to England

The trust had 829,560 first and follow up outpatient appointments from July 2018 to June 2019. The graph below represents how this compares to other trusts.

(Source: Hospital Episode Statistics)

Number of appointments by site

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from July 2018 to June 2019. The appointments attributed to the trust were those where the site was not specified.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk and Norwich University Hospital</td>
<td>1,029,129</td>
</tr>
<tr>
<td>Cromer Hospital</td>
<td>61,447</td>
</tr>
<tr>
<td>Grove Road Ophthalmology Clinic</td>
<td>14,857</td>
</tr>
<tr>
<td>Norfolk and Norwich University Hospitals NHS Foundation Trust</td>
<td>10,377</td>
</tr>
<tr>
<td>The Roundwell Medical Centre</td>
<td>4,657</td>
</tr>
<tr>
<td><strong>This trust</strong></td>
<td><strong>1,133,638</strong></td>
</tr>
<tr>
<td><strong>England</strong></td>
<td><strong>109,956,821</strong></td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)
Type of appointments

The chart below shows the percentage breakdown of the type of outpatient appointments from July 2018 to June 2019. The percentage of these appointments by type can be found in the chart below:

Number of appointments at Norfolk and Norwich University Hospitals NHS Foundation Trust from July 2018 to June 2019 by site and type of appointment

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

(Previously rated as requires improvement)

Mandatory Training

The service provided mandatory training in key skills to all staff, however, not everyone had completed it. Qualified nursing staff and allied health professional staff compliance was below the trust targets in a number of topics.

As the service was managed by each division, the trust wide data is essential to understand compliance for all staff working within outpatients.

Mandatory training completion rates

Nursing staff received and kept up-to-date with their mandatory training. Data provided by the trust showed that trust wide nursing staff were compliant in eight out of 12 topics. However, topics of noncompliance included essential skills such as basic life support and resuscitation. There was a similar picture with medical staff training compliance, with three topics below the trust target of 90%. Also including basic life support and resuscitation. Details of trust wide compliance can be found in the tables below.

Trust level

The trust set a target of 90% for completion of mandatory training.
A breakdown of compliance for mandatory training courses from August 2018 to July 2019 at trust level for qualified nursing staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
<td></td>
</tr>
<tr>
<td>Fire safety</td>
<td>97</td>
<td>101</td>
<td>96.0%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>97</td>
<td>101</td>
<td>96.0%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Infection prevention (level 2)</td>
<td>93</td>
<td>98</td>
<td>94.9%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>95</td>
<td>101</td>
<td>94.1%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>79</td>
<td>85</td>
<td>92.9%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Medicine management training</td>
<td>87</td>
<td>95</td>
<td>91.6%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>88</td>
<td>97</td>
<td>90.7%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Clinical record keeping</td>
<td>88</td>
<td>97</td>
<td>90.7%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Information governance</td>
<td>90</td>
<td>101</td>
<td>89.1%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Basic life support</td>
<td>80</td>
<td>90</td>
<td>88.9%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Resuscitation</td>
<td>16</td>
<td>19</td>
<td>84.2%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>5</td>
<td>8</td>
<td>62.5%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

In outpatients the 90% target was met for eight of the 12 mandatory training modules for which qualified nursing staff were eligible. In addition, a further two modules had completion rates 88.9% and 89.1%, just below the trust target of 90%.

There were no medical staff allocated specifically to outpatients; this is due to staff being allocated to their main speciality.

Qualified allied health professional staff received and kept up-to-date with their mandatory training. Again, compliance with basic life support and resuscitation was below the 90% target.

A breakdown of compliance for mandatory training courses from August 2018 to July 2019 at trust level for qualified allied health professionals in outpatients is shown below. All of these staff were based at Norfolk and Norwich University Hospital.

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
<td></td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>114</td>
<td>120</td>
<td>95.0%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Clinical record keeping</td>
<td>112</td>
<td>120</td>
<td>93.3%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>112</td>
<td>120</td>
<td>93.3%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Fire safety</td>
<td>110</td>
<td>120</td>
<td>91.7%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Information governance</td>
<td>110</td>
<td>120</td>
<td>91.7%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Infection prevention (level 2)</td>
<td>109</td>
<td>119</td>
<td>91.6%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Basic life support</td>
<td>105</td>
<td>120</td>
<td>87.5%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>75</td>
<td>92</td>
<td>81.5%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Resuscitation</td>
<td>30</td>
<td>50</td>
<td>60.0%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

Outpatients

In outpatients the 90% target was met for six of the nine mandatory training modules for which qualified allied health professionals were eligible.
The mandatory training was comprehensive and met the needs of patients and staff. Training was completed either online or face to face depending on the topic. Staff said that training was accessible, and time was given to enable them to complete it. Clinical leads were promoting the completion of mandatory training and reminding staff to complete training, however, it was not always possible to release staff from clinical duties to complete training due to the high activity within the areas.

Managers monitored mandatory training and alerted staff when they needed to update their training. When possible, training was highlighted on off duty and time give for staff to complete.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Staff were able to describe how they would change appointments to facilitate patients with additional needs. We saw that additional time was given to patients with additional needs to ensure that they understood what was happening with appointments and treatments. Staff were also able to refer to additional services and specialists if there were any concerns, for example, the mental health team.

Norfolk and Norwich University Hospital

Nursing staff received and kept up-to-date with their mandatory training. There were two topics below 90% compliance. Staff told us that they had booked on courses to improve compliance.

A breakdown of compliance for mandatory training courses from August 2018 to July 2019 for qualified nursing staff in outpatients at Norfolk and Norwich University Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resuscitation</td>
<td>15</td>
<td>15</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>87</td>
<td>89</td>
<td>97.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>86</td>
<td>89</td>
<td>96.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>86</td>
<td>89</td>
<td>96.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention (level 2)</td>
<td>84</td>
<td>87</td>
<td>96.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>78</td>
<td>84</td>
<td>92.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>78</td>
<td>84</td>
<td>92.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>79</td>
<td>86</td>
<td>91.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>81</td>
<td>89</td>
<td>91.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Clinical record keeping</td>
<td>78</td>
<td>86</td>
<td>90.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic life support</td>
<td>70</td>
<td>79</td>
<td>88.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In outpatients the 90% target was met for 10 of the 12 mandatory training modules for which qualified nursing staff at Norfolk and Norwich University Hospital were eligible. In addition, one of the modules had a completion rate just below the trust target of 90%.

There were no medical staff allocated specifically to outpatients at Norfolk and Norwich University Hospital; this was due to staff being allocated to their main speciality.

Qualified allied health professional staff received and kept up-to-date with their mandatory training. A breakdown of compliance for mandatory training courses from August 2018 to July 2019 for qualified allied health professionals in outpatients at Norfolk and Norwich University Hospital is shown below. All of these staff were based at Norfolk and Norwich University Hospital.
In outpatients the 90% target was met for six of the nine mandatory training modules for which qualified allied health professionals at Norfolk and Norwich University Hospital were eligible.

**Cromer Hospital**

Nursing staff were eligible to receive mandatory training; however, compliance was below the trust target for eight out of 12 topics. A breakdown of compliance for mandatory training courses from August 2018 to July 2019 for qualified nursing staff in outpatients at Cromer Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>114</td>
<td>120</td>
<td>95.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Clinical record keeping</td>
<td>112</td>
<td>120</td>
<td>93.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>112</td>
<td>120</td>
<td>93.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>110</td>
<td>120</td>
<td>91.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>110</td>
<td>120</td>
<td>91.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention (level 2)</td>
<td>109</td>
<td>119</td>
<td>91.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic life support</td>
<td>105</td>
<td>120</td>
<td>87.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>75</td>
<td>92</td>
<td>81.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>30</td>
<td>50</td>
<td>60.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In outpatients the 90% target was met for five of the 12 mandatory training modules for which qualified nursing staff at Cromer Hospital were eligible.

There were no medical staff allocated specifically to outpatients at Norfolk and Norwich University Hospital; this was due to staff being allocated to their main speciality. For details of consultants mandatory training, please see the relevant speciality reports.

There were no qualified allied professional staff reported to be working in outpatients at Cromer Hospital.

(Source: Routine Provider Information Request (RPIR) – Training tab)
Safeguarding

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

Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training.

Trust level

A breakdown of compliance for safeguarding training courses from August 2018 to July 2019 at trust level for qualified nursing staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent - level 3</td>
<td>93</td>
<td>95</td>
<td>97.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>95</td>
<td>98</td>
<td>96.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>87</td>
<td>98</td>
<td>88.8%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In outpatients the 90% target was met for two of the three safeguarding training modules for which qualified nursing staff were eligible. In addition, the remaining module had a completion rate just below the trust target of 90%.

A breakdown of compliance for safeguarding training courses from August 2018 to July 2019 at trust level for qualified allied health professionals in outpatients is shown below. All of these staff were based at Norfolk and Norwich University Hospital.

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent - level 3</td>
<td>105</td>
<td>113</td>
<td>92.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>85</td>
<td>93</td>
<td>91.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>102</td>
<td>119</td>
<td>85.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>22</td>
<td>26</td>
<td>84.6%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In outpatients the 90% target was met for two of the four safeguarding training modules for which qualified allied health professionals were eligible.

There were no medical staff allocated specifically to outpatients; this was due to staff being allocated to their main speciality. For details of consultants safeguarding training, please see the relevant speciality report.

Norfolk and Norwich University Hospital

Nursing staff and allied health professionals received training specific for their role on how to recognise and report abuse. We were told that training was completed at face to face and online sessions. Staff told us training was easily accessible.
A breakdown of compliance for safeguarding training courses from August 2018 to July 2019 for qualified nursing staff in outpatients at Norfolk and Norwich University Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Prevent - level 3</td>
<td>83</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>85</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>80</td>
</tr>
</tbody>
</table>

The 90% target was met for all of the three safeguarding training modules for which qualified nursing staff in outpatients at Norfolk and Norwich University Hospital were eligible.

A breakdown of compliance for safeguarding training courses from August 2018 to July 2019 for qualified allied health professional staff in outpatients at Norfolk and Norwich University Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Prevent - level 3</td>
<td>105</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>85</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>102</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>22</td>
</tr>
</tbody>
</table>

The 90% target was met for two of the four safeguarding training modules for which qualified allied health professional staff in outpatients at Norfolk and Norwich University Hospital were eligible.

Staff could give examples of how to protect patients from harassment and discrimination, including those protected characteristics under the Equality Act. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. We were given examples of when staff had escalated concerns and made appropriate referrals to the safeguarding team. Data provided by the trust showed there had been three outpatient referrals to safeguarding for the 12 months up to July 2019.

Staff were aware of female genital mutilation (FGM), domestic violence and child sexual exploitation (CSE) and told us that if there were any concerns they would speak directly to the trust leads, or doctor for advice. There were posters displayed throughout the outpatient’s departments detailing support groups and contact numbers for patients who wished to seek support. Gynaecology outpatient staff spoke about a recent referral they completed and told us that they openly discussed concerns amongst the team.

Staff followed safe procedures for children visiting the department. There was a separate children’s outpatients department, but we saw that when children accompanied adult patients, all attempts were made to ensure that they were kept safe. Staff were also able to identify vulnerable children and knew who to contact if they had any concerns.

Staff ensured that patients had access to chaperones if necessary. Some clinics had designated chaperones in place, whilst others provided them if the patients confirmed that they would like the support. Posters were not on display in all areas, but we were told and saw that staff asked patients at the start of each appointment.
Cromer Hospital

A breakdown of compliance for safeguarding training courses from August 2018 to July 2019 for qualified nursing staff in outpatients at Cromer Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Prevent - level 3</td>
<td>10</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>10</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>7</td>
</tr>
</tbody>
</table>

The 90% target was met for two of the three safeguarding training modules for which qualified nursing staff in outpatients at Cromer Hospital were eligible.

There were no medical staff allocated specifically to outpatients at Norfolk and Norwich University Hospital; this is due to staff being allocated to their main speciality.

There were no qualified allied professional staff reported to be working in outpatients at Cromer Hospital.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Cleanliness, infection control and hygiene

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

All clinic areas were visibly clean and had suitable furnishings which were well-maintained. An external provider cleaned outpatient areas a minimum of daily, this included waiting areas and bathrooms. All clinical equipment and treatment areas were cleaned by the nursing team.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Equipment in all departments was labelled that it was ready for use. Any reusable medical device was sent to the decontamination department in line with national guidance. Endoscopes, were cleaned appropriately between patients.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We saw that clinic rooms were checked at the start of each clinic and cleaned by the staff member at the end of each session. Any couches or equipment used for physical examinations were cleaned between patients. Staff used a checklist in each room to ensure that cleaning was completed.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were observed wearing gloves and aprons appropriately and washing their hands before and after patient contact. Each area completed hand hygiene audits, and we saw that the results were displayed on notice boards within waiting areas. Hand hygiene scores were recorded above 95%. Hand sanitising gel was accessible to patients on entry to clinical areas, although there were no prompts for patients to use it.

If patients were identified as having a communicable infection prior to their appointment, they were given appointments at the end of the clinic, to minimise the risks of cross infection. We were told that rooms would be thoroughly cleaned after use by a patient with a communicable infection.
The service generally performed well for cleanliness. Local audits were completed in all clinical areas and we saw that cleanliness was recorded as over 99%. The service also performed well for the condition and appearance of facilities with audit scores greater than 90% in all areas.

Material privacy curtains were used in all areas. Nursing staff reported that these were routinely changed every three months, or if they became soiled. Although we saw no register of changes.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, some sterile equipment was found to be out of date.

There were two outpatient departments at Norfolk and Norwich University Hospital. Both were accessible from the main car parks and clearly signposted. Outpatients departments were located across all levels of the buildings and access was easy. There were lifts and stairs to each department.

The design of the environment followed national guidance. There were two types of rooms, those which were used for clinical examinations only, and those which incorporated a consultation area and clinical examination area. The larger rooms had folding doors or curtains which could be closed to provide additional privacy for patient undergoing examinations. Handwashing sinks were available in all examination rooms.

At our last inspection we identified that equipment was not consistently serviced in line with manufacturers guidelines. During this inspection, we saw that equipment had been serviced, however, throughout our inspection, we heard conflicting evidence about the oversight arrangements for this. We were told by nursing staff that they were responsible for arranging services, and for identifying what equipment was needed. We were also told that the trust had a contract manager who looked at equipment across the hospital. Clinical leads told us that there was an asset register for each area and staff receive alerts as to what equipment needs servicing. We were also told that some equipment was highlighted as a risk, due to its age, and therefore had been placed on the risk register.

Nursing staff told us that when equipment was purchased, the manufacturer provided training if necessary. Items would then be placed on the maintenance schedule for annual review. Staff using equipment were required to flag the need for servicing to the estates department. The trust was in the process of devising an equipment replacement programme, with life critical equipment being prioritised.

The service had enough suitable equipment to help them to safely care for patients. Staff carried out daily safety checks of specialist equipment. There were checklists within each department detailing the checks to be made and staff completed these before each working day. We saw that some clinics shared emergency equipment, such as resuscitation trolleys, however, equipment was easily accessible, and staff knew its location. Some departments shared the responsibility for the checking of equipment with other departments. This was usually managed well, however, we saw that within ophthalmology there were a few days when equipment had not been checked. Staff within ophthalmology reported that these checks were supposed to have been completed by the plastics outpatient team. We also saw minimal gaps in the checking of emergency equipment within the gynaecology outpatient unit.

Within the children’s assessment unit (CAU- Jenny Lind), we found multiple items of sterile products which had expired. Items included blood bottles, nasopharyngeal airways, intravenous cannula and an intraosseous needle. The expiration dates were between December 2018 and
December 2019. We removed these items and asked for staff to check the whole stock to ensure there were no additional out of date items in stock. We undertook an unannounced visit on the 19 December 2019 and found no out of date stock items. There was also out of date equipment found within the ophthalmology outpatients department, where defibrillator pads had expired in November 2019.

Most of the outpatient’s treatment / clinic rooms were fitted with emergency call bells. Where emergency call bells were not located, staff were very clear about the risks and the need for speedy responses to any verbal calls for help from colleagues.

Staff disposed of clinical waste safely. Staff used appropriate colour coded waste bags for clinical and non-clinical waste. Sharps bins were labelled and closed to ensure safety. Waste was segregated. Clinical waste was stored in dirty utility rooms, or in designated areas and collected daily.

Within the children’s outpatient’s department, we found that cleaning product were stored in an unlocked cupboard within the dirty utility room. Whilst it was unlikely that unauthorised people or children could access this, this was not in line with the Control of Substances Hazardous to Health Regulations.

There was a process in place to identify any equipment used for invasive procedures. For example, within the ear nose and throat (ENT) outpatient’s department, there was a log of any endoscope used for a procedure, along with the patients’ details, the type of procedure and the equipment identification. This process ensured traceability.

Any clinical specimens collected during an outpatient’s appointment were labelled, segregated and handled appropriately. We saw that porters collected samples at regular intervals.

We saw that there was a cleaning schedule for toys used across the children’s outpatient’s department and within the children’s assessment unit.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them appropriately. Patient observations were generally recorded in outpatient clinics. Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. This depended on the type of appointment being completed. For example, if a patient was attending outpatients for a preadmission appointment, all observations and risk assessments would be completed to ensure there was an accurate baseline prior to the patient’s admission. However, if a patient was attending an appointment to see a consultant only, no risk assessments were completed. Most patients had clinical observations, such as blood pressure and pulse rate taken.

Staff responded promptly to any sudden deterioration in a patient’s health. If a patient was identified as being unwell at the appointment, there was a clear process for admission to hospital. We were given examples of when a patient had become unwell at their appointment and clinical staff liaised directly with the inpatient area and the site management team to arrange an admission to the appropriate ward. Nursing staff told us that ward staff were usually accommodating and would accept the patient as soon as possible after the referral to ensure the patients safety.

Staff knew about and dealt with any specific risk issues. Staff were aware of patients risks
associated with the type of patients attending clinics. For example, staff within the wound management clinic were aware of sepsis and the signs of infections. There were clear pathways to escalate concerns. Nursing staff could access medical staff or nurse specialist easily. We saw that nurse specialists usually accompanied consultants during clinic times, either seeing their own list of patients or assisting the doctor with their appointment. Staff told us this was particularly useful when breaking bad news, as the specialist nurses were available to support patients who may have been told they have a life changing illness.

At our last inspection we saw that trust audits showed World Health Organisation (WHO) surgical safety checklist use was not embedded across the service. The completion of this checklist pre, during and post procedures keeps patients safe from avoidable harm or errors if followed correctly. The five steps to safer surgery include: team brief, sign-in, time-out, sign-out and debrief. During this inspection, we saw that this had improved. We were told that the WHO checklist was completed for most invasive procedures within outpatients.

National Safety Standards for Invasive Procedures (NatSSIPs) were available in most clinical areas. NatSSIPs provide a framework for the production of Local Safety Standards for Invasive Procedures (LocSSIPs). Staff showed us where LocSSIPs had been introduced, for example, within gynaecology and ophthalmology outpatient’s department. However, there was no standardised process for the management or development of these. Staff reported that the use of the WHO safer surgery checklist was used for some procedures, whilst local LocSSIPs were used for others. Staff within ophthalmology had a working group to look at LocSSIPs and were planning to introduce more across the service. Those LocSSIPs in place had been reviewed by the trust and had been ratified.

The service did not have 24-hour access to mental health liaison and specialist mental health support but could refer patients if necessary. Referrals were completed through a telephone referral system, which enabled staff to speak to a mental health specialist. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide, although these were rarely completed in outpatient and usually completed by an appropriately trained practitioner.

If a patient became aggressive, or violent during an appointment, staff were able to call security for support. Staff told us that an incident form would be completed, and the patients record would be updated with a flag to identify the risks, which would enable staff to identify risks prior to any subsequent appointments. This meant that staff could arrange for appointments to be completed with two practitioners for safety.

Staff shared key information to keep patients safe when handing over their care to others. There was clear communication between staff within each department. There were robust processes to identify which patients were scheduled for appointments, those that were in the department and those who needed multiple interventions, for example, nursing clinical assessment, vision testing, consultation and investigations, such as blood tests. Staff kept track of all patients within the department to ensure that the appropriate clinician saw all patients. Shift changes and handovers included all necessary key information to keep patients safe. We saw that staff shift changes did not usually fall in the middle of clinics, however, nurses had clear roles and responsibilities could handover to colleagues if necessary. We saw that most clinics held clinic huddles, which was a briefing session for all staff. These included details of clinic activity, any issues with staffing or equipment, scheduling, tasks for the day and escalation processes.

Appropriately trained staff managed the children’s outpatients’ clinic and assessment area. Staff were either registered children’s nurses or had access to a registered children’s nurse. We saw that there was a designated treatment room for children who presented in the department with serious illnesses. The room included resuscitation equipment and was located next to the nurse’s station to ensure that children were always observed. The children’s outpatient department had
designated medical cover 24 hours per day.

Nursing staff within the children’s assessment unit reported that if a patient required additional support for mental health issues or a mental health assessment, they were able to increase staffing numbers to ensure that the child/young person had someone to support them until an assessment was completed. The child and adolescent mental health service (CAMHS) was provided by an external provider and accessible between 8am and 6pm, with an on-call service out of hours. Staff reported that CAMHS was usually responsive to any calls for assistance with managing patients.

**Nurse staffing**

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. There appeared to be a difference in staff allocation for surgical and medical speciality clinics. We saw that each department had a manager, but within surgical clinics, each consultant appeared to have an accompanying healthcare assistant providing chaperoning if necessary. Within medicine, there did not appear to be as many nurses within the department. Healthcare assistants were available but covered one or two clinic rooms.

**Trust level**

The table below shows a summary of the nursing staffing metrics in outpatients at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>August 2018 to July 2019</th>
<th>July 2018 to June 2019</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Annual average establishment</td>
<td>Annual vacancy rate</td>
<td>Annual turnover rate</td>
</tr>
<tr>
<td>Target</td>
<td></td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>All staff</td>
<td>432</td>
<td>5%</td>
<td>10%</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>81</td>
<td>4%</td>
<td>9%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Nurse staffing rates within outpatients were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy. The trust only provided data on bank use for four months and therefore analysis of change over time was not possible. No agency usage was reported.

**Vacancy rates**
The service had low and/or reducing vacancy rates.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

The service had low and/or reducing turnover rates.

![Turnover rate graph](image)

Monthly turnover rates over the last 12 months for qualified nurses, health visitors and midwives showed an upward trend from November 2018 to March 2019, although this did not continue.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

The service had low and/or reducing sickness rates.

![Sickness rate graph](image)

Monthly sickness rates over the last 12 months for qualified nurses, health visitors and midwives showed a shift from January 2019 to June 2019. This could be an indicator of change. We were told that there had been work completed to review staffing and ensure that staff were managed through the appropriate HR processes. This had resulted in changes to staffing in several areas.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and agency staff usage**

The service had low and/or reducing rates of bank and agency nurses. This was in response to...
Managers limited their use of bank and agency staff and requested staff familiar with the service. Where possible, we were told that the same bank or agency staff were used to ensure continuity. This was reported as being essential to clinic who used a high number of specialist equipment such as the ophthalmology clinics. Using the same staff meant that substantive staff did not have to train multiple people on equipment used. Managers made sure all bank and agency staff had a full induction and understood the service.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Norfolk and Norwich University Hospital

The table below shows a summary of the nursing staffing metrics in outpatients at Norfolk and Norwich University Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>August 2018 to July 2019</th>
<th>July 2018 to June 2019</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Annual average establishment</td>
<td>Annual vacancy rate</td>
<td>Annual turnover rate</td>
</tr>
<tr>
<td>Target</td>
<td>10%</td>
<td>10%</td>
<td>0%</td>
</tr>
<tr>
<td>All staff</td>
<td>412</td>
<td>5%</td>
<td>10%</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>69</td>
<td>5%</td>
<td>9%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

The service had enough nursing and support staff to keep patients safe. Clinic staffing numbers were reviewed annually by the senior nursing team. Staff told us that they were able to escalate any concerns with staffing to the matron who then liaised with the wider nursing team to identify support.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The ward manager could adjust staffing levels daily according to the needs of patients. Clinic staff told us that ward staff would occasionally assist if staffing was below the requirements and activity was high, however this did not happen very often. Staff also said that they often supported ward staff if ward staffing levels were below establishment.

The number of nurses and healthcare assistants matched the planned numbers. At each clinic visited during inspection, staffing numbers were as planned, except for the children’s outpatient’s unit where one member of staff had called in sick. In response to this, the nurse in charge for the emergency children’s outpatient’s unit was overseeing both clinical areas and supporting staff to manage the workload. The matron for the service was also supporting staff to ensure patient safety.

Vacancy rates
The service had low and/or reducing vacancy rates.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Nursing staff reported minimal vacancies across all areas, however, did report that specialist roles were difficult to recruit to. For example, retinal photography within ophthalmology.

**Turnover rates**

The service had low and/or reducing turnover rates.

[Turnover rate graph]

Monthly turnover rates over the last 12 months for qualified nurses, health visitors and midwives showed an upward trend from November 2018 to March 2019, although this did not continue.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

The service had low and/or reducing sickness rates.

[Sickness rate graph]

Monthly sickness rates over the last 12 months for qualified nurses, health visitors and midwives showed a shift from January 2019 to June 2019. This could be an indicator of change.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)
Bank and agency staff usage

The service had low and/or reducing rates of bank and agency nurses. Managers limited their use of bank and agency staff and requested staff familiar with the service. We were told that bank and agency staff rarely worked within the outpatient’s department as they were not familiar with the services, however, there were a few staff who worked regularly in some clinics. Ophthalmology outpatients told us that they had invested time in training a couple of bank staff, which meant that they were able to call on a suitably trained individual in the event of a short notice absence.

Managers made sure all bank and agency staff had a full induction and understood the service. All staff were given a local induction and a nominated person to go to for support.

*(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)*

Cromer Hospital

The table below shows a summary of the nursing staffing metrics in outpatients at Cromer Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>August 2018 to July 2019</th>
<th>July 2018 to June 2019</th>
<th>August 2018 to July 2019</th>
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<tbody>
<tr>
<td></td>
<td>Annual average establishment</td>
<td>Annual vacancy rate</td>
<td>Annual turnover rate</td>
</tr>
<tr>
<td>Target</td>
<td></td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>All staff</td>
<td>20</td>
<td>1%</td>
<td>11%</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>12</td>
<td>-2%</td>
<td>10%</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)*

Nurse staffing rates within end of life care at Cromer Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy and turnover. The trust only provided data on bank use for four months and therefore analysis of change over time was not possible. No agency usage was reported.

Please note that the negative vacancy rate for nursing staff in the table above indicates that there were more staff in post than planned.

Vacancy rates

The service had low and/or reducing vacancy rates.

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

Turnover rates
The service had low and/or reducing turnover rates.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

The service had low and/or reducing sickness rates.

![Sickness rate graph]

Monthly sickness rates over the last 12 months for qualified nurses, health visitors and midwives showed an upward trend from February 2019 to June 2019. This could be an early indicator of deterioration.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Medical staffing**

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

There were no medical staff allocated specifically to outpatients at the trust; this is due to staff being allocated to their main speciality.

Clinics were arranged depending on consultant availability. Staff reported that if a doctor was absent at short notice, the speciality attempted to cover to prevent cancelling clinics.

Some services had on call doctors, but this was managed by the speciality and patients were not admitted to outpatient areas out of normal working hours. The only exception to this was the children's assessment unit (CAU), where there was a designated consultant 24 hours per day. The consultant would be available within the department during the day and on call. The ward doctors supported them. Overnight the CAU medical staffing included one registrar and a senior house officer.

**Qualified allied health professional staffing**

The service had enough allied health professionals with the right qualifications, skills,
training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough qualified allied health professional staff (AHPs) to keep patients safe. We saw that AHPs generally managed their own clinics and workloads. Appointments were largely scheduled according to their availability and if sickness or short notice absence occurred, the team endeavoured to cover any appointments to prevent cancellations.

**Trust level**

The table below shows a summary of the qualified allied health professional staffing metrics in outpatients at trust level compared to the trust’s targets, where applicable. All of these staff were recorded as being based at Norwich and Norfolk University Hospital.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>10%</td>
<td>10%</td>
<td>3.9%</td>
</tr>
<tr>
<td>All staff</td>
<td>432</td>
<td>5%</td>
<td>10%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Qualified allied health professional staff</td>
<td>99</td>
<td>7%</td>
<td>9%</td>
<td>2.5%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Qualified allied health professional locum tabs)

Qualified allied health professional staffing rates within outpatients were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and sickness.

**Vacancy rates**

Monthly vacancy rates over the last 12 months for allied health professionals showed a downward shift from February 2019 to July 2019. This could be an indicator of change.
The service had low and/or reducing vacancy rates for qualified allied health professional staff.  
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

The service had low and/or reducing turnover rates for qualified allied health professional staff.  
(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

The service had low and/or reducing sickness rates for qualified allied health professional staff.  
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Norfolk and Norwich University Hospital**

The table below shows a summary of the qualified allied health professional staffing metrics in outpatients at Norfolk and Norwich University Hospital compared to the trust’s targets, where applicable.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>August 2018 to July 2019</th>
<th>July 2018 to June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Annual average establishment</td>
<td>Annual vacancy rate</td>
</tr>
<tr>
<td>Target</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>All staff</td>
<td>412</td>
<td>5%</td>
</tr>
<tr>
<td>Qualified allied health professional staff</td>
<td>99</td>
<td>7%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Qualified allied health professional locum tabs)

Qualified allied health professional staffing rates within outpatients were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and sickness.

**Vacancy rates**
Monthly vacancy rates over the last 12 months for allied health professionals showed a downward shift from February 2019 to July 2019. This could be an indicator of change.

The service had low and/or reducing vacancy rates for qualified allied health professional staff.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

The service had low and/or reducing turnover rates for qualified allied health professional staff.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

The service had low and/or reducing sickness rates for qualified allied health professional staff.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Cromer Hospital**

There were no qualified allied professional staff reported to be working in outpatients at Cromer Hospital.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Qualified allied health professional locum tabs)

**Records**

Staff kept records of patients’ care and treatment. Records were easily available to all staff providing care. However, notes were not always clear or stored securely.

At our last inspection, we saw that storage of records for patients waiting for consultation was not always secure and this had been raised on the previous two inspections. During this inspection, we saw that the secure storage of medical records continued to be an issue.
Records were not always stored securely, although some areas had changed practice to prevent unauthorised persons potentially accessing patient records. For example, we saw that the cardiology outpatients’ team, placed patients notes directly in the consultation room with the consultant, preventing unauthorised access. Other departments ensured that patients were accompanied from the waiting area to the consulting room which meant that patients were not able to walk unaccompanied through corridors. However, we saw that most areas, placed patients notes on trolleys outside consulting rooms once the patient had confirmed attendance and their initial assessment by a nurse completed. Within surgical specialities, patients’ notes were left outside the consulting room unattended until the consultant called the patient in for their appointment. Staff reported that they had trialled different processes, such as placing notes directly in consulting rooms, however, this meant that there was a risk of confusing patients. Some departments reported that they were trialling different trolleys, however, these were not in place, which meant that there was a continued risk of unauthorised persons accessing patients records.

Patient notes were not comprehensive, although staff could access them easily. We reviewed 14 sets of notes across all clinics visited and found that the quality of notes was poor. Patient files were largely old, broken folders, held together with elastic bands. Inside the files, notes were not in a set order, consisted of loose papers and did not contain details of all activities. For example, we saw that some clinics where patients had been reviewed by a specialist nurse recorded notes at the time of appointment. There were clear data entries relating to the appointment, any physical examination, and changes to plans. There was also evidence of communication with the patients GP with updates of the outcome from the appointment. We saw that there were no notes within the surgical outpatients’ records. We were told that doctors dictated notes for these appointments, and details would be added later. However, this meant that there was no clear record of activity within the patient notes and there was a potential risk for the patient to be admitted to hospital and their records would not contain the most up to date information. We were also told that within surgical specialities, the patients did not always receive a copy of their appointment letter, with the decision as to whether the patient should be included in a copy of the information being down to the individual. Medical specialities copied patients in on all correspondence.

Once a patient was added to the clinic, the notes were requested from the medical notes department. There was a clear process for the management of notes through the clinics. The ward clerk would check that notes were available and move them from the pending pile to the arrived pile when the patients checked in at the reception. Nursing staff would then collect the notes and complete any necessary interventions prior to the clinic appointment. Following completion of the intervention, the notes would be moved to the consultant or specialist practitioners pile for patients to be seen. Reception staff told us that notes were nearly always available before appointments, and they rarely had to chase or try to locate notes.

Following the outpatient appointment, medical notes were transferred to the medical secretary for updating with copies of the appointment letters, and then transferred to the medical records department. Any letters produced because of the appointment were added to the file at this point. GP and specialist referral letters were sent by email to the appropriate practitioner and we saw that some were completed at the time of the appointment, preventing delays in patient pathways.

When patients transferred to a new team, there were no delays in staff accessing their records. There was a robust process in all clinic areas for notes to be returned to the medical records department following completion of appointment letters. Following a clinic appointment, notes were transferred to the medical secretary for updating and then returned to medical records.

Nursing staff told us that they had multiple IT systems to use, particularly for patients with cancers. This was due to the national database for reporting and the complexity of some
treatments. Whilst staff appreciated the need to capture data, they felt that they spent time duplicating information in different systems and formats.

Within the trauma and orthopaedic outpatient department, there was a poster detailing the correct procedure for dictating a letter. This had been devised locally to provide consultants with guidance on the ‘dos and don'ts’, to ensure a standardised letter.

**Medicines**

**The service had systems and processes to prescribe, administer, record and store medicines. However, these were not always followed or in line with guidance.**

At our last inspection we saw that the service did not follow best practice when recording and storing medicines in outpatients. There had been issues with the process for collating and auditing prescription sheets which can be issued externally to the hospital (FP10s). The main concerns related to the recording of numbers of FP10s being used and the lack of oversight of the number of FP10 sheets used in each clinic. During this inspection, we found that there continued to be issues with the safe management of FP10. Whilst efforts had been made to remove FP10 from outpatients’ clinics in exchange for hospital prescription sheets, FP10s were still used within the ophthalmology outpatient’s department and the children’s assessment unit and outpatient’s department. Within ophthalmology, the service maintained a daily check of numbers of prescriptions within the department and were moving towards a record of all the prescriptions completed which would include the person it was issued to and the medicine that was prescribed. However, within the children’s departments, we found that there were no checks in place, either relating to the number of prescriptions in the department, their location or their use. This was escalated at the time of inspection and processes were put in place to ensure that prescriptions could be tracked.

Staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines. Medicines were not always stored safely, or in line with guidance. We saw that fridge temperatures were not always checked daily, and there was little evidence to support that actions had been taken in response to temperatures outside the recommended levels. We looked at temperature readings of seven fridges and found four recorded temperatures outside the recommended levels. For example, within gynaecology outpatients, we found that, a temperature greater than 8 degrees Celsius had been recorded on multiple days and there was no record of actions taken. There were also frequently occasions where the temperature had read lower than 2 degrees Celsius. When we escalated this to the manager, we were told that the pharmacist had been informed and any medicine that was temperature sensitive had removed from the fridge. However, we found influenza vaccines within the fridge. Vaccine efficacy would be affected if stored outside the recommendations. This was escalated at the time of inspection and action taken to ensure safety.

We saw that staff recorded ambient temperatures of treatment rooms where medicines were stored. We saw that the temperatures recorded were often higher than the recommended upper level for safe storage according to the trust’s checklist, however, there was no evidence of any actions taken in response to this. For example, we saw that the surgical outpatient’s treatment room recorded a temperature greater than 25 degrees Celsius throughout July 2019, with some days recorded as 30 degrees Celsius. There was no evidence to support that staff had escalated any concerns regarding the safe storage of medicines to the pharmacy department. This was escalated at the time of inspection.

The cupboard labelled as being used for controlled drugs within the day procedure unit did not comply with the Misuse of drugs act (safe custody) regulations. Controlled drugs are those that have additional checks in place under the Misuse of Drugs Act 1971 and the Misuse of Drugs
Regulations 2001. There are requirements for controlled drugs to be stored in specifically designed cupboards, separate from normal stock medicines. This was escalated to the unit manager who liaised with pharmacy to arrange suitable storage. We saw that controlled drugs were checked by two nurses when administered and that the pharmacy department completed regular checks of stock levels and the drug register.

The service had a system to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. However, these were not always effective. We identified one medicine in two departments which had been recalled by the Medicines and Healthcare products Regulatory Agency (MHRA). The MHRA is an executive agency which is responsible for ensuring that medicines and medical devices work and are acceptably safe. We found two boxes and four boxes of a recalled medicine in the preop assessment unit and the day procedure unit. We escalated this to the trusts pharmacy department and the medicines were removed.

Within gynaecology outpatients we also saw that lignocaine cartridges were stored alongside ward/ unit stock. This was not in line with best practice and lignocaine should be stored in the original containers for safety. Lignocaine is a medicine to numb a specific area (local anaesthetic). There were also several unlicensed medicines found in the ward/ unit stock. This was escalated to the nurse in charge and pharmacy during inspection.

We saw that treatment rooms were not always large enough to accommodate the medicines used within the clinics. For example, within gynaecology, we found that intravenous fluids were stored in boxes on the floor instead of on shelving, due to the lack of space.

There was not always clear signage for areas storing medical gases. For example, we saw that Entonox and oxygen were found in the gynaecology outpatients treatment room. There was no signage on the doors to notify staff of this.

Staff reviewed patient’s medicines regularly and provided specific advice to patients and carers about their medicines. We saw that staff reviewed the patient medicines when attending for an appointment and advised the patient on any changes. We saw that the pre-operative assessment unit, had a dedicated pharmacist who worked with the team and reviewed patients’ medicines before and after admission. This person had access to the patients records and was able to check that the patients was taking the correct medicines. Staff reported that this had improved accuracy of medicines.

Staff stored and managed all medicines and prescribing documents in line with the provider’s policy. We saw that staff in the outpatient’s units largely worked to a patient group directive (PGDs). This is the process whereby some staff can administer specific medicines to a pre-defined group of patients, without the patient seeing a prescriber (such as the nurse or doctor). For example, PGDs are widely used in ophthalmology for patients with specific eye conditions, without the patient seeing a doctor. We saw that staff completed competencies in administering medicines using a PGD, however, once staff had been deemed competent, there was no process to ensure ongoing competence. There was no PGD audit to confirm compliance.

Staff followed current national practice to check patients had the correct medicines. We saw that the patient’s medicines were reviewed by the nurse or doctor completing the outpatient’s appointment and checked the medicines against those on the patients discharge list. Details of the patient’s medicines were recorded on the patients discharge letter following an inpatient stay at hospital, and a copy was sent to the patients GP and copy given to the patient. Staff used this for follow up appointment to check details of any medicines.

Decision making processes were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines.
There was pharmacy support to all departments with the pharmacy being open between 8am and 5.45pm Monday to Friday and 9am to 4pm on Saturdays. Staff reported that the pharmacy team were supportive and would assist with any queries.

**Incidents**

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

All staff knew what incidents to report and how to report them. The service used an electronic system for recording incidents and staff told us that this was easy to use. Staff raised some concerns and reported incidents and near misses in line with trust/provider policy. However, we were told that staff did not always report incidents, for example, late starting or overrunning clinics. Staff reported that they would consider reporting these occurrences if there was a delay or over run by over 40 minutes. Staff said that they would report any incident that affected patient safety, such as short staffing and equipment failures.

Once an incident was reported electronically, they were automatically sent to the manager of the clinical areas for investigation. Managers investigated incidents and recorded any actions taken to reduce the risks of reoccurrence.

Staff did not always receive feedback from investigation of incidents, whether internal or external to the service. Staff told us feedback varied according to the type of incident. They routinely received feedback about more serious incidents but did not get feedback from ‘routine’ incidents reported. For example, we were told that staff did not report consultants attending clinics late as they did not receive feedback and ‘nothing appeared to be done’ in response to the incident report being generated. Clinical leads told us that actions had been taken in response to concerns about timekeeping, but actions were managed within individual specialities and not shared across the service.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Where possible, patients and their families were involved in investigations. Managers debriefed and supported staff after any serious incident. Staff met to discuss the feedback and look at improvements to patient care following serious incidents.

**Never Events**

The service had no never events on any wards.

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.

From October 2018 to September 2019, the trust did not report any never events for outpatients.

(Source: Strategic Executive Information System (STEIS))
Managers shared learning with their staff about never events that happened elsewhere. Staff were able to speak about learning from never events which had occurred in other departments.

**Breakdown of serious incidents reported to STEIS**

**Trust level**

Staff reported serious incidents clearly and in line with trust policy. In accordance with the Serious Incident Framework 2015, the trust reported nine serious incidents (SIs) in outpatients which met the reporting criteria set by NHS England from October 2018 to September 2019. A breakdown of incidents by incident type are below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>6</td>
<td>66.7%</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI criteria (including failure to act on test results)</td>
<td>2</td>
<td>22.2%</td>
</tr>
<tr>
<td>Confidential information leak/information governance breach meeting SI criteria</td>
<td>1</td>
<td>11.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

We saw that serious incidents were investigated thoroughly, by the most appropriate person. For example, if the incident referred to a medical incident, the investigation was completed by someone from the appropriate speciality. Each investigation had an associated action plan.

**Safety Thermometer**

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The safety thermometer was 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 was intended to focus attention on patient harms and their elimination.

Data collection 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.

Safety thermometer data was displayed in clinics for staff and patients to see. We were told that staff had been given new display boards, which contained sections for key information to be displayed including safety thermometer data. We saw that clinics had a notice board near the main entrance or waiting areas which showed details of cleanliness audits, local safety thermometer data, and any complaints.
Is the service effective?

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The hospital used nationally recognised guidance and standards relating to patient safe care and treatment. Policies and procedures were in place, reflected national guidance, and were available on the intranet. We saw that staff could easily locate what they needed. Policies reviewed reflected best practice and were in date.

Clinical effectiveness was supported through staff training and development. Policies were based on the National Institute for Health and Care Excellence (NICE) guidance and were compared at a regional and national level.

We were told that procedures such as hysteroscopies and cystoscopies were completed in line with national guidance. Local procedures had been developed in line with the National Safety Standards for Invasive Procedures (NatSSIPs). Nursing staff explained that the speciality was continuing to review guidance and develop local standards for other procedures.

There was a structured audit programme to ensure practice was reviewed. We were told that audits included clinical care and ensured that staff followed policy. For example, infection prevention, infection rates and speciality audits. We saw that local audits were reviewed across services to identify any areas for development.

Where possible, patient pathways were followed for clinical conditions or procedures. For example, national guidance and pathways were used for patients undergoing orthopaedic or cancer procedures. Staff used relevant cancer databases to report activity for benchmarking and audit purposes.

Staff protected the rights of patients’ subject to the Mental Health Act and followed the Code of Practice. Where appropriate, staff referred patients for support from the mental health team and if necessary advocates to support decision making.

There were very few handovers, due to patients attending hospital appointments for short periods only. However, if staff were referring patients to another service, at handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

**Nutrition and hydration**

Outpatients services did not routinely provide nutrition and hydration for patients. This was because, patients were attending for a short period only.

There were cafes located close to each outpatient’s area, so patient and their relatives could access refreshments if necessary.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. For example, we were told that any patient who was waiting for hospital transport was provided with a meal if they waited for any length of time. Nursing staff also told us that if a patient was a known diabetic and needed a meal, they were given a bleep, so they knew when to come back to the department for their appointment. This meant that they were able to
seek their own refreshments without concerns that they will miss their appointment slot. Patients had access to fresh water in all department as each had a water fountain close to the waiting area. Some had coffee machines for hot drinks.

Staff did not routinely use nationally recognised screening tools to monitor patients at risk of malnutrition within outpatients, however, we saw that there was a standardised system in use across the hospital and outpatient staff were aware of this.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. We saw that patients identified as needing additional support from dietitians and speech and language therapist had access to them following a referral.

Pain relief

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

Staff assessed patient’s pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients were not routinely provided with pain medicines in outpatients, and patients routinely brought in their own medicines when attending for an appointment. However, if a patient was attending for an invasive appointment, pain control medicines were available and administered in line with the prescription.

Staff prescribed, administered and recorded pain relief accurately. We saw that when pain was recorded, it was described clearly along with any actions taken to resolve it. Staff used tools for patients who were unable to speak English, communicate verbally and for children.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service did not participate directly in national clinical audits; however, specialities did report into sections of national audits. For example, orthopaedic outpatients participated in patient reported outcome measures (PROMS), which measures health gain in patients undergoing orthopaedic procedures such as hip replacements. For information on national audits, please see the relevant speciality report.

The physiotherapy department participated in the hip fracture and integrated shoulder service (ISS) audits, which looked at patient’s satisfaction with treatment. The ISS audit showed that 75% of patients were happy with their treatment. Staff reported that additional work was being completed on training packages for therapists to improve patient satisfaction.

The outcome of patients’ appointments was recorded through outcome forms. These were completed by the clinician at the end of the patient’s appointment and detailed whether the patient required another appointment, or whether they were to be discharged. Forms were given to the receptionist who recorded the information centrally, ensuring that appointments were scheduled where necessary.

Follow-up to new rate
From July 2018 to June 2019:
- the follow-up to new rate for Norfolk and Norwich University Hospital was similar to the England average.
- the follow-up to new rates for The Roundwell Medical Centre, Cromer Hospital and Grove Road Ophthalmology Clinic were higher than the England average.
- the follow-up to new rate for Norfolk and Norwich University Hospitals NHS Foundation Trust was higher than the England average. These were appointments where the site wasn’t specified.

**Follow-up to new rate, Norfolk and Norwich University Hospitals NHS Foundation Trust.**

![Graph showing follow-up rates for different locations]

(Source: Hospital Episode Statistics)

Managers and staff used audit results to improve patient outcomes. For example, within gynaecology outpatients, there was clear understanding of audit results and how the service performed in comparison to the national standards. Staff told us that they were able to identify where improvements were needed and worked with the whole team to manage any areas for development.

Managers and staff used audit results to improve patient outcomes. Ophthalmology staff told us that there was a lot of research within the speciality and staff were always asked to participate in new treatments or services.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Local audits were completed daily, weekly or monthly depending on the area. We were given example of when junior staff completed audits daily and a senior nurse completed them once per week to ensure compliance. This was used as a development tool for staff, whereby the senior nurse would ensure that the junior staff fully understood the audit, the process and the findings.

Managers shared and made sure staff understood information from the audits. We saw that audit results were displayed where possible in common staff areas and ward meetings and governance meetings covered audits and their results.

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and
development. However, compliance with appraisals did not meet the trust targets for all staff groups.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. We were told that in addition to mandatory training, managers were eager to develop staff in other topics. For example, the general surgery outpatient’s manager had identified a need for additional training in sepsis and was planning to use a governance day to complete additional training with the staff.

Staff within the children’s assessment and outpatient unit were suitably trained and experienced to manage the sick child. The unit accepted walk in and GP referral patients, and consequently required additional skills such as paediatric life support.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge where possible. Staff told us that they could access internal and external training, however, due to activity and limited placements this was not always possible.

Managers made sure staff received any specialist training for their role. Healthcare assistants completed a two-week course when they commenced their post. Managers gave all new staff a full induction tailored to their role before they started work. Qualified staff completed additional competencies specific to the area worked. Each speciality had specific competencies which were required to be completed at the start of a substantive post. These could be signed off by a competent practitioner.

Managers identified poor staff performance promptly and supported staff to improve. We were given examples of where staff had been identified as struggling with specific activities or their role and they were provided with support and mentorship.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Discussions usually took place during annual appraisals, however, staff told us they could speak to the clinic manager at any point to discuss training opportunities. Clinic managers told us that they met with their matron weekly. The meetings were usually informal and provided the staff with the opportunity to discuss any management concerns, services performance and any knowledge/ training needs.

**Appraisal rates**

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff told us that appraisals were sometimes scheduled but not completed due to demands of the service.

**Trust level**

From April 2018 to March 2019, 78.7% of staff within the outpatient’s department at the trust received an appraisal compared to a trust target of 85%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Healthcare scientists</td>
<td>1</td>
</tr>
<tr>
<td>Additional professional scientific and technical</td>
<td>10</td>
</tr>
<tr>
<td>Staff group</td>
<td>April 2018 to March 2019</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Healthcare scientists</td>
<td>1</td>
</tr>
<tr>
<td>Additional professional scientific and technical</td>
<td>10</td>
</tr>
<tr>
<td>Estates and ancillary</td>
<td>2</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>79</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>87</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>71</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>57</td>
</tr>
</tbody>
</table>

Norfolk and Norwich University Hospital

From April 2018 to March 2019, 78.3% of staff within the outpatient’s department at Norfolk and Norwich University Hospital received an appraisal compared to a trust target of 85%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>14</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>8</td>
</tr>
</tbody>
</table>

Cromer Hospital

From April 2018 to March 2019, 84.6% of staff within the outpatient’s department at Cromer Hospital received an appraisal compared to a trust target of 85%.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend. Departmental files contained key information about meetings and training. For example, we saw a file within gynaecology outpatients which had copies of the last speciality governance meetings as well as local team meetings. This enabled staff to keep up to date with what was happening within the speciality and across the trust.

The clinical educators supported the learning and development needs of staff. These were external to the outpatient’s services and worked across the trust. However, we were told that clinical educators supported divisions in training staff and standardising practice across all areas.

Clinical nurse specialists (CNSs), were often the key contact for patients with long term conditions and illnesses. We were told that they had received additional training in communication skills to enable them to hold sensitive conversations with patients such as breaking bad news and discussing cancer treatments. Clinic staff were also able to access...
communication training if deemed appropriate for their roles.

**Multidisciplinary working**

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. As clinics worked within specialities, we saw that there was effective communication. Depending on the speciality, multidisciplinary meetings were held a minimum of weekly. Staff from the outpatient’s department were able to attend these sessions, along with doctors, ward staff, matrons, radiologists and clinical nurse specialists. Patient care was planned and delivered in a coordinated manner. For example, patients attending the orthopaedic outpatient department would have any relevant investigations, such as an x-ray, prior to their consultation to enable the investigation to be reviewed.

Staff worked across health care disciplines and with other agencies when required to care for patients. Although we did not see any interactions between physical health and mental health practitioners, nursing staff told us working relationships were effective and respectful. Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. We were told that the mental health assessment was completed as a separate appointment.

Patients could see all the health professionals involved in their care in one-stop clinics. Staff ensured that clinical nurse specialists, doctors and allied health professionals were available for complex appointments, such as breast clinics. This ensured that patients only attended the hospital on one occasion.

**Seven-day services**

**Key services were available seven days a week to support timely patient care.**

Clinic times varied across all specialities. For example, we saw that the children’s assessment unit was open 24 hours per day. Other clinics, such as the ear, nose and throat (ENT) clinic worked predominantly Monday to Friday, with core business hours 8.30am to 5.30pm. Ophthalmology offered a weekend service with patients being seen in clinics from 8am to 5.30pm on Saturdays and 8am to 12md on Sundays. Medical speciality clinics offered a routine six-day service (Monday to Saturday) 8am to 6pm, in addition to a late clinic (until 8pm) on a Tuesday and a Sunday morning clinic. Most specialities had an on-call services outside core business hours.

In addition to completing clinics, doctors were required to cover inpatient activity. Clinic staff reported that this sometimes impacted on the doctor’s ability to arrive in clinic on time, as a sick patient required their attention elsewhere. Staff told us that if necessary they could add a patient to the clinic list as an emergency. Nursing staff in the plastics outpatient’s department told us that they often arranged an urgent appointment prior to the clinic, to fit in with the doctor’s availability before their normal working day. This meant that patients would not need to wait for available appointments to be seen in an emergency.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, seven days a week. Most investigations were arranged for patients as an outpatient appointment, however, doctors were able to access diagnostic testing urgently if a patient presented unwell at their outpatients’ appointment. If this occurred, the patient was usually admitted to hospital.
We saw that clinical nurse specialists (CNSs) conducted their own clinic. CNSs had dedicated clinic times within each speciality to enable them to manage their patients effectively. We were told that CNS clinics were usually arranged on days when there were less doctors available. For example, CNSs conducted clinics on Fridays within ophthalmology, as this was the quieter clinic day.

**Health Promotion**

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

The service had relevant information promoting healthy lifestyles and support on the units. Throughout all departments we saw appropriate information for patients regarding healthier lifestyles. Staff also held conversations regarding healthier lifestyles. For example, within the cardiology department, staff spoke openly with patients about weight management and smoking cessation.

Staff assessed each patient’s health when attending appointments and provided support for any individual needs to live a healthier lifestyle. Cardiology offered patients support groups and rehabilitation programmes to promote health and recovery from illnesses.

Patients who had received life changing diagnosis, or those with long term conditions were supported through the clinical nurse specialists and the wider team. We saw that staff signposted patients to information leaflets, associations and support groups.

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

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff had completed training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).

Each department had a safeguarding, Mental Capacity Act (MCA), learning disability (LD) and dementia lead. These leads were usually a member of the team who had a specific interest in the topic and had been encouraged to learn more and attend trust wide groups as a link nurse. We saw that some link nurses provided additional information in clinical areas to promote knowledge.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Consent was clearly recorded and written in notes and on consent forms. Consent to examinations and invasive procedures was clearly recorded in patients notes. For example, we saw within the gynaecology outpatient’s department, the nurses had clearly recorded consent to a physical examination and treatment.

When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions. We were given an example of when staff had become concerned that a patient lacked capacity, and this was escalated to the doctor. Nursing staff reported that a best interest meeting was arranged with the patient, their carer, the doctor and nursing team, to determine what actions needed to be taken. Staff reported that following the meeting, the patient was deemed to have capacity to agree to the procedure planned.
Staff made sure patients consented to treatment based on all the information available. We saw that side effects and contra indications were discussed as part of consent procedures.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. We were given examples of when staff had supported children and young adults to make informed decisions about their care and treatment. Staff described the transitioning services available for patients with an identified long-term condition, who were transitioning from children to adult services.

Mental Capacity Act and Deprivation of Liberty Safeguards training completion

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The trust set a target of 90% for completion of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training.

Trust level

A breakdown of compliance for MCA/DoLS training courses from August 2018 to July 2019 at trust level for qualified nursing staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act level 2</td>
<td>91</td>
</tr>
<tr>
<td>Deprivation of Liberty Safeguards</td>
<td>91</td>
</tr>
</tbody>
</table>

In outpatients the target was met for both MCA/DoLS training modules for which qualified nursing staff were eligible.

There were no medical staff allocated specifically to outpatients; this is due to staff being allocated to their main speciality.

A breakdown of compliance for MCA/DoLS training courses from August 2018 to July 2019 at trust level for qualified allied health professional staff in outpatients is shown below. All of the staff were based at Norfolk and Norwich University Hospital.

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act level 2</td>
<td>100</td>
</tr>
<tr>
<td>Deprivation of Liberty Safeguards</td>
<td>100</td>
</tr>
</tbody>
</table>

In outpatients the target was not met for either MCA/DoLS training modules for which qualified allied health professional staff were eligible.

Norfolk and Norwich University Hospital

A breakdown of compliance for MCA/DoLS training courses from August 2018 to July 2019 at Norfolk and Norwich University Hospital for qualified nursing staff in outpatients is shown below:
In outpatients the target was met for both of the MCA/DoLS training modules for which qualified nursing staff at Norfolk and Norwich University Hospital were eligible.

There were no medical staff allocated specifically to outpatients; this is due to staff being allocated to their main speciality.

A breakdown of compliance for MCA/DoLS training courses from August 2018 to July 2019 at Norfolk and Norwich University Hospital for qualified allied health professional staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>100</td>
</tr>
<tr>
<td>Deprivation of Liberty Safeguards</td>
<td>100</td>
</tr>
</tbody>
</table>

In outpatients the target was not met for either of the two MCA/DoLS training modules for which qualified allied health professional staff at Norfolk and Norwich University Hospital were eligible.

Cromer Hospital

A breakdown of compliance for MCA/DoLS training courses from August 2018 to July 2019 at Cromer Hospital for qualified nursing staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>10</td>
</tr>
<tr>
<td>Deprivation of Liberty Safeguards</td>
<td>10</td>
</tr>
</tbody>
</table>

In outpatients the target was met for both MCA/DoLS training modules for which qualified nursing staff at Cromer Hospital were eligible.

There were no medical staff allocated specifically to outpatients at Norfolk and Norwich University Hospital; this is due to staff being allocated to their main speciality.

There were no qualified allied professional staff reported to be working in outpatients at Cromer Hospital.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Safeguarding leads were accessible to clinic staff and we were told that they were responsive when concerns were escalated to them.

Managers monitored the use of Deprivation of Liberty Safeguards (DoLS) and made sure staff knew how to complete them. Staff gave us examples of when safeguarding concerns had been escalated within the department. We were given an example of a teenage pregnancy, which was reported as a safeguarding concern due to the age of the mother. Staff were very clear on their
roles and responsibilities in safeguarding.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. The policy was located on the trust intranet.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. Staff reported that they completed referrals sporadically but were aware of the processes and requirements.

There was a process for staff to identify any patients who was at risk without detailing the concerns in the patient records. Staff used a specific marker that was placed on the cover of the patients’ medical notes to act as an alert and signify that there had been safeguarding concerns about that patient before. This process meant that if there were any concerns noted during the appointment, staff could speak to the safeguarding team and seek additional information to inform decision making.
Is the service caring?

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed multiple interactions between staff and patients or carers, all were considered. Staff were friendly and engaged in conversations.

Patients said staff treated them well and with kindness. All patients we spoke with reported that staff had treated them well.

Staff followed policy to keep patient care and treatment confidential. We saw signage to say that notes were confidential, used in the medical outpatient’s department. This acted as a barrier to prevent unauthorised patients reading notes. In other clinic areas, patients’ notes were out of sight to patients reporting for appointments. Reception staff took care to prevent patient conversations being overheard and all appointments were conducted in private clinical areas.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff reported that if a patient was identified as having additional requirements due to mental health issues, longer appointments would be facilitated. This enabled them to have sensitive conversations and ensure that they fully understood what was happening.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patients told us that their preferences were taken into consideration when discussing and planning care.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients and their relatives were given time to discuss care and treatment and were kept informed throughout their pathway.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We saw that clinics were routinely locked when in use and privacy curtains were drawn across doorway as an additional barrier. Patients who became distressed during procedures were given clear information about the length of time left for the examination and asked to confirm if they were happy to continue. Staff told us that they frequently paused to comfort distressed patients prior to continuing with appointments.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. All clinics used consultation rooms which enabled patients to have a private space for difficult conversations. Staff would provide patients time on their own, or with their loved one to think about news being given.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. Staff encouraged patients to speak about their
concerns and treatment plans. Where necessary specialists were included in conversations. WE saw that clinical nurse specialists were usually present when patients were given life changing diagnosis, as they were the patients link for their ongoing treatments.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. We saw that doctor, nurses and specialist practitioners such as therapists and clinical nurse specialists took time to explain procedures, treatment options and care pathways.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff were able to access pictorial cards or prompts to support communication with patients who were not able to communicate verbally.

Staff supported patients to make advanced decisions about their care. Information was shared about treatment options at appointments. We saw that staff spent time explaining patients’ options to enable them to make an informed decision about their care.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Within the children’s assessment unit, children were able to feedback whether they felt the service they received was “tops” or “pants”. There were coloured clothing items (tops and pants) which could be picked out, written on if necessary and posted for staff to know how their care had been received. The service also used the friends and family test (FFT) to capture patient feedback. We saw that patient feedback was largely positive. FFT information was shared with the public, as displayed on waiting room notice boards.

Staff reported that it was difficult to obtain feedback from patients because patients were only in the hospital for a short period of time. Where possible, patient feedback was used to improve services. We were given one example of how the general surgery outpatients department had acted upon feedback. Patients with cancer had commented that when they visited the department they saw leaflets about cancers everywhere, and this was a reminder of their condition. The patient felt it would be better to have leaflets located in one area, which meant that patients could seek the information if they wished but did not have to see the leaflets every time they visited. In response, the service developed a hub, where information leaflets were located.
Is the service responsive?

Service delivery to meet the needs of the local people

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

At our last inspection we found people could not always access the service when they needed it. Waiting times from referral to treatment were not in line with good practice. Cancer waits had deteriorated. At this inspection, we saw that there continued to be issues with the referral to treatment times. The service had introduced additional clinics where possible, but the demands on the service remained high. For details of referral to treatment times, please see the relevant core service report.

Managers planned and organised services, so they met the changing needs of the local population. Clinical leads told us that they were looking at future planning to ensure that there would be suitable services available to patients in the future, not just now. Leads had started to look to neighbouring organisations to design patient pathways which were sustainable and would meet the needs of the patients.

Outpatient services were located in two main blocks either side of the main hospital entrance. These were clearly sign posted as East and West Outpatients. On entry to each block, there was a reception desk, manned by volunteers who could assist with directions or mobility. Lifts and stair wells were clearly signposted and there were clear signs detailing where each service was located.

Patients received appointment letters in advance. These detailed the department where the appointment was scheduled and details of car parking/ transport, location of the clinic, the consultant/ person and time.

There were two large car parks adjacent to the outpatient’s blocks, however we saw that these were used for all visitors to the hospital. Patients did not tell us they had difficulty parking, however, we saw that there was always queues.

Clinics were open generally between 8am and 6pm, Monday to Friday, however, some offered services outside these times. For example, medical outpatients provided appointments up to 8pm on a Tuesday. Some clinics were routinely open at weekends, for example, medical outpatient and ophthalmology, whilst others completed additional clinics at weekends if activity was high.

The facilities and premises were appropriate for the services that were being delivered. With the exception of the plastics outpatient’s department, all clinics had sufficient space to complete their activity. Within the plastics department, we saw that the treatment area consisted of a relatively small space with four cubicles. Staff reported that this was often cramped due to the type of dressings being completed. Other clinical areas told us they had reduced space for storage, such as gynaecology and ophthalmology. Within these areas, we saw that all available space was being utilised for storing equipment, notes and guidance. This included the kitchen, in gynaecology where we saw staff information files and displays and equipment in the ophthalmology ‘treatment room’.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. We saw that where possible, patients’ appointments were coordinated with other activities, such as blood tests, investigations and other specialists, such as nurses or allied health professionals.
The service had systems to help care for patients in need of additional support or specialist intervention. If a patient attended a clinic appointment and was found to need additional support or interventions, they were referred to the appropriate service immediately. We saw that staff completed referral letters at appointments. Patients who had been identified as requiring additional support prior to the clinic appointment were catered for. For example, if the patient had a learning disability (LD), the LD nurse would arrange to attend as a familiar face. Patients notes were highlighted with stickers if there were any known needs, such as LD, dementia or safeguarding.

Staff provided patients with pagers if they needed to leave the clinic waiting area for any reason. We were given examples of patients who were waiting for transport home who wanted to leave the waiting room to go to the café, and staff gave the patient a ‘tracker’ so they knew when they needed to return.

Managers monitored and took action to minimise missed appointments. Patients received a reminder about appointments via a telephone text message. Staff recorded none attendance at appointments and told us that is a patient did not attend three appointments, they were referred to their GP.

Managers ensured that patients at risk who did not attend appointments were contacted. Staff reported that they did not routinely contact all patients who did not attend for a planned appointment, however they made a judgement on the risks associated with the missed appointment and then either contacted the patient directly or the patients GP.

Did not attend rate

From July 2018 to June 2019,
- the ‘did not attend’ rates for Cromer Hospital, Grove Road Ophthalmology Clinic and Norfolk and Norwich University Hospital were lower than the England average.
- the ‘did not attend’ rate for The Roundwell Medical Centre was mostly higher than the England average.

The chart below shows the ‘did not attend’ rate over time.

Proportion of patients who did not attend appointment, Norfolk and Norwich University Hospitals NHS Foundation Trust

(Source: Hospital Episode Statistics)

The service relieved pressure on other departments when they could treat patients in a day. We
were given examples of how departments worked collaboratively with inpatient areas to manage patient flow through the hospital. For example, providing treatments to enable patients to be discharged following their completion, or agreeing to accept the patient onto earlier clinics to facilitate an earlier discharge from hospital.

**Meeting people’s individual needs**

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

Staff made sure patients living with mental health problems, learning disabilities (LD) and dementia, received the necessary care to meet all their needs. Nursing staff used appropriate specialists to inform appointment scheduling when possible. If a patient was known to have additional needs, prior to an appointment, staff would liaise with the relevant specialist to gather any additional information which may be of use. Appointment times or locations could be adjusted to suit the patients’ needs. There was also an automatic alert system, whereby a patient with a known need would be flagged automatically to the nurse specialist if an appointment was booked. This meant that the specialist nurse could contact the department in advance to make any necessary arrangements. Staff told us that if a patient presented for the first time and there were concerns about their understanding, they would delay any decision making and contact the doctor.

There was a rapid risk assessment in place, which could be accessed by every person with a LD. This focused on the provision of key components to provide a safe supportive admission. For example, use of hospital passport or pain profiles. Nursing staff told us that they would ensure that any patient with additional needs would be called into their appointment as soon as possible after arrival in the department. Patients with a LD were escorted into an empty room and the consultant or practitioner would come to them, which assisted with reducing anxieties of entering an occupied room.

Staff reported that they were aware of the ‘this is me’ document. Staff understood that it was important to ensure that the patients’ needs were considered when completing an appointment and adjusted their communication when necessary. Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff spoke about the ‘pride’ course which provided staff with additional training on communication skills. Staff had access to communication aids to help patients become partners in their care and treatment. This included communication aids, pictorial charts and the iPad for translation.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. Staff were able to access translators in person if necessary, and nursing staff told us that they used an application on trust iPads to assist with translations. Staff had access to people who could use British sign language (BSL), but none were trained in its use.

The service did not have information leaflets available in languages spoken by the patients and local community. Leaflets were written in English only. There were a wide range of leaflets available across all outpatients’ departments. We saw that some were produced by the trust, whilst others were from patient associations, charities or medical companies. Most trust leaflets were in date, although some had no review date.

Examination room doors were closed when rooms were occupied. Staff routinely knocked on doors before entering. Within surgical specialities there was no signage to say whether the room was occupied or not, however, within medicine we saw that signage was clear on each door. In clinic rooms where physical examinations were completed, there was a privacy curtain which
could be pulled across the door to prevent patients being observed if doors were opened.

We saw that within surgical outpatient clinics, a chaperone was usually allocated to the room at the start of each clinic. There were no signs prompting patients to ask for a chaperone. Within medicine, patients were asked if they required a chaperone at the commencement of their appointment. Staff were available to assist as chaperones if necessary. Medical specialities provided a chaperone for all appointments which included a physical or intimate examination.

We were given examples of how appointments were changed to meet the needs of patients. For example, one patient attending the gynaecology outpatient’s department was immobile and required a hoist transfer. Nursing staff had arranged for this patient to be admitted to the ward for their appointment, which would provide a more comfortable experience.

Within medical specialities, patients being transported by ambulance were often prioritised upon arrival as they arranged an ambulance wait service. This meant that the ambulance would remain with the patient for a designated period. If the patient was not accompanied by the ambulance crew, staff would call the service every 30 minutes to ensure transport was coming. Staff arranged snack boxes for patients who were waiting in the department for any length of time, ensuring that they were available for the transport at any point.

We saw that there were appropriate facilities for children in the children’s assessment unit and outpatient’s department. There were several toys and designated play areas for children.

Staff completed dementia training and there was a specialist team they could contact for support. Nursing staff liaised with elderly wards to ensure that any issues with hearing were addressed to avoid any confusion between a patient’s ability to hear and their understanding. Dementia patients were offered spare hearing aids to ease stress if their own aid went missing. Digital copies of ear moulds were stored to avoid having to do them again.

**Access and flow**

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

Referrals into the services varied. Most referrals were from patients GPs for a consultation about a specific concern. In addition, clinics had regular appointments for patients with long term ongoing conditions, or in follow up to an admission to hospital. We also saw that areas like the children’s assessment unit and ophthalmology received referral from walk in centre and emergency admissions (such as walk in to emergency department).

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Each speciality had a waiting list for clinic appointments and then treatments. Waiting lists were monitored by each division and centrally by the executive team, and these were reviewed regularly to determine needs and performance.

Performance varied within specialities. For example, we saw that the 18 week wait referral to treatment times for non-admitted pathways was below the England average. Although some specialities performed better than the England average to meet these targets (for example, geriatric medicine, rheumatology, general surgery and cardiology). Others did not, for example, gynaecology, ophthalmology, general medicine and plastic specialities. There was a similar picture with the 18-week incomplete referral to treatment times. Details can be found below.

Data also showed that the trust performed similar to the England average in the standard for
patients to be diagnosed with cancers in less than 31 days. However, the referral to treatment time for patients receiving treatment for cancers was lower than the England average, which mean that patients were waiting longer. Details can be found below.

**Referral to treatment (percentage within 18 weeks) – non-admitted pathways**

From September 2018 to May 2019 the trust’s referral to treatment time (RTT) for non-admitted pathways was consistently lower than the England overall performance. The trust performed similar to the England average from June to August 2019.

The latest figures for August 2019, showed 84.0% of this group of patients were treated within 18 weeks versus the England average of 85.6%.

**Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Norfolk and Norwich University Hospitals NHS Foundation Trust**

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty**

From September 2018 to August 2019, 10 specialties were above the England average for non-admitted pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>96.2%</td>
<td>94.8%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>94.6%</td>
<td>84.7%</td>
</tr>
<tr>
<td>General surgery</td>
<td>92.4%</td>
<td>88.2%</td>
</tr>
<tr>
<td>Neurology</td>
<td>91.1%</td>
<td>76.6%</td>
</tr>
<tr>
<td>Other</td>
<td>89.5%</td>
<td>89.2%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>88.7%</td>
<td>80.3%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>88.5%</td>
<td>79.4%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>87.7%</td>
<td>85.7%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>85.0%</td>
<td>84.9%</td>
</tr>
<tr>
<td>Urology</td>
<td>84.3%</td>
<td>83.5%</td>
</tr>
</tbody>
</table>
Seven specialties were below the England average for non-admitted pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gynaecology</td>
<td>89.2%</td>
<td>90.2%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>85.3%</td>
<td>88.0%</td>
</tr>
<tr>
<td>General medicine</td>
<td>85.1%</td>
<td>90.8%</td>
</tr>
<tr>
<td>Ear, nose &amp; throat (ENT)</td>
<td>81.1%</td>
<td>82.9%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>75.1%</td>
<td>89.9%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>67.1%</td>
<td>87.1%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>65.2%</td>
<td>85.3%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – incomplete pathways

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, Norfolk and Norwich University Hospitals NHS Foundation Trust

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

From September 2018 to August 2019, nine specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General medicine</td>
<td>100.0%</td>
<td>90.5%</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>99.3%</td>
<td>95.3%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>96.9%</td>
<td>89.6%</td>
</tr>
<tr>
<td>Neurology</td>
<td>96.0%</td>
<td>84.7%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>94.6%</td>
<td>88.7%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>93.8%</td>
<td>86.7%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>88.8%</td>
<td>88.4%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>86.6%</td>
<td>85.2%</td>
</tr>
</tbody>
</table>
Eight specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
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<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>85.2%</td>
<td>87.7%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>84.9%</td>
<td>88.2%</td>
</tr>
<tr>
<td>General surgery</td>
<td>82.7%</td>
<td>83.2%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>78.5%</td>
<td>80.9%</td>
</tr>
<tr>
<td>Urology</td>
<td>78.1%</td>
<td>83.6%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>75.2%</td>
<td>86.5%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>71.4%</td>
<td>81.8%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>69.9%</td>
<td>80.5%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

**Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)**

The trust performed consistently lower than the 93% operational standard and generally lower than the England average for people being seen within two weeks of an urgent GP referral from quarter 2 of 2018/19 to quarter 1 of 2019/20 (July 2018 to June 2019).

Trust performance improved from 74% of patients seen within two weeks in quarter 2 of 2018/19 to 89% in quarter 1 of 2019/20. The performance over time is shown in the graph below.

**Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), Norfolk and Norwich University Hospitals NHS Foundation Trust**

(Source: NHS England – Cancer Waits)

**Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)**

The trust performed similar to the 96% operational standard and England average for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). The performance over time is shown in the graph below.

**Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), Norfolk and Norwich University Hospitals NHS Foundation Trust**
Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The trust performed lower than the 85% operational standard and England average for patients receiving their first treatment within 62 days of an urgent GP referral. On average 68% of patients at the trust waited less than 62 days to receive treatment.

The performance over time is shown in the graph below.

Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, Norfolk and Norwich University Hospitals NHS Foundation Trust

The trust performed consistently lower than the England average for referral to treatment time (RTT) for incomplete pathways for 11 of the 12 months over the period from September 2018 to August 2019, the only exception being August 2019.

In August 2019, figures showed that 81.8% of this group of patients were treated within 18 weeks versus the England average of 77.6%.

When the patient’s referral was received, they were added to a clinic list. These were planned in advance and details of appointments sent to the patients. Clinic lists were available to staff in advance to enable them to access the patients records for the appointment.

On arrival to the department, patients reported to the receptionist to confirm that they had arrived. Patients were then crossed off the list. There was a clear process for when clinics were running late. Nursing staff reported delays to the receptionist daily at 10.30am and 3.30pm. This enabled
the receptionist to make an announcement to patients of the current waiting times. Reception staff reported that this was a very daunting process as they were not sure of how delays would be received by waiting patients. Delays were not routinely monitored, although the gynaecology outpatient department reported that the matron was currently auditing overrunning clinics, this will include a review of job plans. Staff reported that they would only escalate concerns or report overrunning or late clinics if there was a delay over 30-40 minutes.

Managers worked to keep the number of cancelled appointments/treatments to a minimum. Patients were reminded of appointments in advance and given contact details for when appointments were not convenient enabling them to be rescheduled and any gaps filled with another patient.

When patients had their appointments/treatments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. We were told that clinics were rarely cancelled, however, when cancellations occurred staff endeavoured to add patients to the next available slots. Additional clinics were held if necessary to meet demands. Some services provided ‘hot clinics’ which were same day or next day appointments. We were given examples, of when patients had been slotted in to appointments due to clinical concerns.

Clinical nurse specialists managed their own workload and were therefore able to flex appointments. This was particularly useful for patients with cancer diagnosis, who may require an urgent appointment to discuss or receive treatments for conditions associated with their treatments.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Feedback forms were located at reception desks, and if patients expressed dissatisfaction with the service, concerns were escalated appropriately. Receptionist told us that if patients expressed concerns about their appointments, nursing staff were responsive and tried to resolve any issues.

Staff understood the policy on complaints and knew how to handle them. Nursing staff told us that any local verbal complaints were escalated to the operations manager, who were very responsive and attended the department immediately. If complaints were received in writing within the departments, they were forwarded to the matron who then escalated to the complaints department. Staff reported that most verbal complaints related to delays.

Managers investigated complaints and identified themes. Staff told us the biggest complaints were around waiting times and appointments. Staff told us that complaints were discussed at all team meetings to enhance awareness of common issues and any actions taken in response to concerns.

At our last inspection we found that the trust took an average of 32 days to investigate and close complaints, and 34.4% of the complaints were closed within 25 days. This was not in line with the trust’s complaints policy, which states that more than 50% of complaints should be closed within 25 days. At this inspection, we saw that this had improved slightly, and complaints were now managed on average, in 28.5 days. However, the policy had been updated to state that deadlines should be agreed with the complainant.
Summary of complaints

Trust level

From August 2018 to September 2019 the trust received 195 complaints in relation to outpatients at the trust (18.1% of the total complaints received by the trust).

The trust took an average of 28.5 working days to investigate and close complaints. The trust’s complaints policy states that complaints should be investigated and closed as agreed with the complainant.

One complaint was still open at the time of reporting, this had been open for 55 working days.

A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communications</td>
<td>48</td>
<td>24.6%</td>
</tr>
<tr>
<td>Appointments including delays and cancellations</td>
<td>44</td>
<td>22.6%</td>
</tr>
<tr>
<td>Clinical treatment - surgical</td>
<td>33</td>
<td>16.9%</td>
</tr>
<tr>
<td>Clinical treatment - general medical</td>
<td>24</td>
<td>12.3%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>10</td>
<td>5.1%</td>
</tr>
<tr>
<td>Values and behaviours (staff)</td>
<td>9</td>
<td>4.6%</td>
</tr>
<tr>
<td>Trust administration</td>
<td>5</td>
<td>2.6%</td>
</tr>
<tr>
<td>Clinical treatment - oncology</td>
<td>4</td>
<td>2.1%</td>
</tr>
<tr>
<td>Facilities</td>
<td>4</td>
<td>2.1%</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>1.5%</td>
</tr>
<tr>
<td>Privacy, dignity and wellbeing</td>
<td>3</td>
<td>1.5%</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>3</td>
<td>1.5%</td>
</tr>
<tr>
<td>Clinical treatment - anaesthetics</td>
<td>2</td>
<td>1.0%</td>
</tr>
<tr>
<td>Commissioning services</td>
<td>1</td>
<td>0.5%</td>
</tr>
<tr>
<td>Admission, discharge and transfers</td>
<td>1</td>
<td>0.5%</td>
</tr>
<tr>
<td>Consent</td>
<td>1</td>
<td>0.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>195</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Norfolk and Norwich University Hospital

From August 2018 to September 2019 there were 185 complaints about outpatients at Norfolk and Norwich University Hospital.

The trust took an average of 28.5 days to investigate and close complaints. The trust’s complaints policy, states that complaints should be investigated and closed as agreed with the complainant, with more than 50% closed within 25 days.

A breakdown of complaints by type is below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communications</td>
<td>47</td>
<td>25.4%</td>
</tr>
<tr>
<td>Appointments including delays and cancellations</td>
<td>41</td>
<td>22.2%</td>
</tr>
</tbody>
</table>
Clinical treatment - surgical | 32 | 17.3%
Clinical treatment - general medical | 23 | 12.4%
Waiting times | 10 | 5.4%
Values and behaviours (staff) | 8 | 4.3%
Trust administration | 5 | 2.7%
Clinical treatment - oncology | 4 | 2.2%
Access to treatment or drugs | 3 | 1.6%
Facilities | 3 | 1.6%
Privacy, dignity and wellbeing | 3 | 1.6%
Clinical treatment - anaesthetics | 2 | 1.1%
Other | 2 | 1.1%
Admission, discharge and transfers | 1 | 0.5%
Consent | 1 | 0.5%
Total | 185 | 100.0%

Cromer Hospital

From August 2018 to September 2019 there were 10 complaints about outpatients at Cromer Hospital.

The trust took an average of 28.9 days to investigate and close complaints. The trust’s complaints policy, states that complaints should be investigated and closed as agreed with the complainant, with more than 50% closed within 25 days.

A breakdown of complaints by type is below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointments including delays and cancellations</td>
<td>3</td>
<td>30%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>10%</td>
</tr>
<tr>
<td>Facilities</td>
<td>1</td>
<td>10%</td>
</tr>
<tr>
<td>Clinical treatment - general medical</td>
<td>1</td>
<td>10%</td>
</tr>
<tr>
<td>Values and behaviours (staff)</td>
<td>1</td>
<td>10%</td>
</tr>
<tr>
<td>Commissioning services</td>
<td>1</td>
<td>10%</td>
</tr>
<tr>
<td>Communications</td>
<td>1</td>
<td>10%</td>
</tr>
<tr>
<td>Clinical treatment - surgical</td>
<td>1</td>
<td>10%</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>100%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff completed investigations in line with the complaint. For example, if a complaint was around the appointment delays, the operations manager would format a response, if the concerns were clinical, the doctor would format the response. In all occasions, the complaint was kept up to date with how the complaint investigation was going.

All complaint responses were processes through the trust central complaints team and signed off by divisional leads and the trust executive team. If necessary, patients were asked if they wished to attend the hospital to discuss their complaint with the relevant persons. This process was adopted for more complex concerns, or those where the complainant remained dissatisfied with
the initial response letter.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff told us that complaints were discussed routinely at governance meetings, enabling sharing of concerns and actions.

**Number of compliments made to the trust**

**Trust level**

From August 2018 to July 2019 there were 65 compliments about outpatients at the trust (3.5% of the total compliments received by the trust). A breakdown of compliments by site is below

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cromer Hospital</td>
<td>23</td>
<td>35.4%</td>
</tr>
<tr>
<td>Norfolk and Norwich University Hospital</td>
<td>42</td>
<td>64.6%</td>
</tr>
<tr>
<td>Total</td>
<td>65</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Since January 2019, the trust aimed to improve collection and recording of compliments. Compliments are reported monthly to the Patient Engagement and Experience Group (PEEG) and there is a monthly analysis of themes. Divisions can access their data for use at local level and for sharing and learning from compliments. Trust wide themes are identified to show how important care, kindness and staff attitude are to the positive experience of patients. Dignity is a key positive theme. A selection of compliments is shared, and individual wards and areas display and share compliments amongst teams.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)
Is the service well-led?

Leadership

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

Outpatients departments were managed by the specialities responsible for the patients care. For example, the surgical directorate was responsible for all surgical, ophthalmology and wound management outpatients appointments. Medical specialities included cardiology, gastroenterology and endocrinology appointments. Each clinical speciality had a clinical lead, lead nurse and operations manager who worked collaboratively to manage and plan treatments and services.

Since our last inspection, staff reported that there had been a number of changes with leadership across the service. There were a number of new matrons and clinic managers. Staff reported that changes had been positive. Clinic managers were approachable, visible and enthusiastic about their roles. Most had offices based within the clinic area and assisted with clinic activity, even on managerial days. New managers reported a strong network for support and development.

Staff told us that divisional leads and operations managers were visible and accessible, however, they rarely saw executive team members. Some staff told us that they attended the ‘4th floor’ presentations, undertaken by the executive team to keep staff informed of plans and developments across the trust. However, these were not always convenient. Staff also reported that senior staff, such as matrons did not routinely visit the departments unless there was something specific they needed to discuss with the team.

Vision and strategy

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

At our previous inspection we found there was no specific long-term vision or strategy for the outpatient services. During this inspection we saw that there was a clear strategy which was aligned to the trust vision. This had been developed through engagement with staff and had clear aims to ensure that patients were at the forefront of service plans. Staff felt that the trust strategy and plan reflected outpatients services and what they wanted to achieve.

There was a trust wide focus on high demand specialities, such as ophthalmology, and services were developing pathways such as telemedicine/telecalls to manage demand and improve efficiency. The clinical leads were clear that this was work in progress and there was no quick solution.

Staff across all specialities spoke about their involvement with the transformation of services, although the outcomes were not clear or fully understood.

Clinical leads spoke about how they were working with the wider healthcare system to ensure efficiency across services. For example, there were regarding consultants completing speciality clinics in neighbouring trusts to improve patient pathways and access to some types of medicine.
Culture

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

Staff felt supported, respected and valued. Most nursing staff told us that they had worked for the trust for a number of years and were generally happy about their roles. There was a clear focus on providing a quality service and staff were patient focused. The demands and pressures on inpatient beds was felt across all areas, and staff told us that they assisted where possible to improve this, either by adding additional clinics, seeing patients on wards or covering vacant shifts when staffing allowed.

Some staff felt that there were limited opportunities for development and would like additional training or access to external course to maintain enthusiasm about their roles. We saw that this varied according to the speciality as areas, such as ophthalmology and cardiology had opportunities for staff to develop new skills within the same speciality.

Staff were proud to work for the organisation and felt that they contributed positively. Staff said that there was a positive team culture. Staff worked collaboratively for the benefit of patients and the service. Staff agreed to complete additional work when clinics were short as they recognised that their colleagues would struggle if the shift was not covered.

Staff told us that they were able to make suggestions on how to improve things, and senior nurses, and clinical leads listened to their opinions. Some staff reported that there had been a cultural shift over the last two to three years, with the focus being on supporting staff.

There was a support network for staff who had been involved with difficult or serious incidents. Staff completed debriefing sessions and could access clinical supervision sessions to discuss the impact of caring for people with cancer, or difficult patients.

Staff also spoke of support across services for each other. We were given an example whereby the cardiology outpatients department was forced to move their clinics in response to a leaking roof. Minimal clinics and appointments were cancelled due to other divisions or specialities worked collaboratively with the cardiology team to offer vacant rooms to enable clinics to continue.

Governance

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

There were effective structures, processes and systems of accountability in place to support the safe delivery of care and treatment. Each division had monthly governance meetings and clinics did not run on these days which enabled staff to attend the meeting or to complete training. Governance meetings followed standardised agendas and included areas of discussion including, performance, complaints and risks. Medical, nursing and allied health professionals attended these. Nursing staff reported that the meetings were sometimes lengthy and therefore staff would not always be able to stay or attend for long due to the overlap with clinics. Key information from these meetings were shared at local team meetings to ensure that all staff were kept up to date with activity.
Key information from governance meetings was escalated to the executive board at regular intervals and staff were held accountable for their performance. Divisional performance and referral to treatment times were discussed and clinical leads were expected to have clear plans on how the service would meet targets.

Senior nursing staff reported that they had weekly meetings with their divisional matron. This was used as a checkpoint to ensure that staff were happy, to share information and updates and discuss performance.

Daily team briefings and monthly team meetings were held. Meeting agendas included friends and family test (FFT) results, incidents, changes to practice. They were minuted and circulated.

There was a robust audit calendar and staff reported findings from audits centrally. This information was used to determine whether the area was compliance with the trust standards. WE saw that staff completed the daily ‘perfect ward’ audit which enabled areas to escalate any concerns. Staff were able to use the ‘perfect ward’ app to take photographs and report any deviances from normal.

**Management of risk, issues and performance**

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

At our previous inspection we found that the outpatient risk register contained 25 risks, eight of which had been on the register for over three years. The trust was not monitoring risks to ensure mitigation was in place or improvements were embedded, for example for medicine room temperature checks or patient record storage.

Staff told us that complaints were discussed routinely at governance meetings, enabling sharing of concerns and actions.

Risk registers were reviewed regularly as part of governance meetings. We saw that each division had monthly governance meetings where risks were reviewed to identify if they were active, whether any mitigation was required or whether they had been resolved. We saw that the risk register contained risks such as lack of clinic space, the cost of replacing equipment, carpeted clinical areas, the use of clinic rooms as inpatient escalation areas and the safe storage of medicines. Risks were reviewed regularly and we saw that mitigation to reduce the risks were clearly recorded.

We saw that clinical areas were aware of their risks. For example, within gynaecology outpatients, there was a poster which detailed the three top risks for the service. These included cancer targets, referral to treatment times (RTT) and medical outliers. Medical outliers are medical patients that are being care for on a non-medical speciality ward.

There was a clear process for risks to be escalated to the trust board. Any risk rated as a high or severe risk was discussed at trust wide risk meetings and if necessary moved to the trust risk register.

There were systems in place to monitor quality and operational and financial processes though audit. Staff completed performance audits and captured data relating to each service provided. These were reviewed and compared across the trust, with peers and national averages. Clinical leads used this to benchmark performance and identify areas where improvements could be
made. This data was also being used in the transformation of services to align demand and provision of services.

**Information management**

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

At our previous inspection we found that the service did not always manage information effectively. Staffing related information held by the trust did not always clearly show outpatient staff, especially for medical staff. During this inspection, we found that outpatient nursing staffing information was available, however, medical staff were aligned to their division.

Staff were aware of the need to maintain confidentiality; medical records were not always secure. However, computer screens were not visible to unauthorised people and computers were locked when not in use. Notes were usually left outside clinic rooms unattended whilst patients were waiting to see the consultant.

Staff told us patient records were easily accessible and available for any appointments. If notes were not available for an appointment, staff would print off the most recent letters to identify why the patient was in the clinic. Staff would then make the decision as to whether to continue to appointment or not. Staff reported appointments usually continued as planned and the missing notes were reported as an incident.

We saw that details of patients appointments were shared with the patients GP. Letters were completed by the person responsible for the care of the patient, and these were either sent electronically or in paper format. Some letters were sent on the same day of the patients' appointment, whilst others were compiled by consultants secretaries and forwarded after a couple of days. Staff told us that GP letters were usually completed within one week of the patients appointment.

Information regarding performance was predominantly kept electronically. This enabled the service to directly compare data across the hospital and used this to inform decision making. We saw that information was shared with staff with copies being recorded in ward meeting minutes.

**Engagement**

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

The trust had completed a number of engagement events with staff since our last inspection, We were told that this had been well received and attended. Staff had been asked to give their opinions on how the services could develop and become more efficient. Staff were asked to be innovative about care delivery. Out of these engagement events, the services had several focus groups looking at different aspects of care delivery, for example, one looking at Local Safety Standards for Invasive Procedures (LocSSIPs), another looking at notes’ storage. We spoke with staff who were part of these focus groups and they reported that whilst the work had just begun, there were a lot of ideas and staff were positive about how this process would improve patient care.

Staff reported positive engagement with divisional meetings and outpatient sisters’ meetings. These were completed every three months and offered clinic managers the opportunity to meet with peers and discuss any concerns, share learning and compete training. These were managed
by divisional leads. There was also an outpatients forum which provided staff who worked outside ward areas to meet and develop more efficient ways of cross service working.

Some clinical areas, such as cardiology outpatients reported good patient engagement. Patients were encouraged to attend focus groups and provide feedback about how the service could be improved. This was easier for some specialities due to the types of services being required. For example, cardiology provided post heart attack rehabilitation sessions which facilitated open discussions about patients’ experiences.

We were told that the trust freedom to speak up guardian had been invited to several divisional meetings, which enabled staff to identify what they were and discuss any concerns openly. Clinic managers reported that senior nurses were not in attendance and they did not receive any feedback about these sessions unless it was appropriate to do so.

**Learning, continuous improvement and innovation**

*All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.*

Staff told us they were being encouraged to think of ways to improve services and efficiency. Staff felt listened to when suggesting ideas. Staff spoke about developing new systems of working to improve efficiency and productivity. The outpatients forum had been developed in November 2019 and used small groups of staff to complete projects such as the standardisation of Local Safety Standards for Invasive Procedures (LocSSIPs).

At our last inspection, we identified that the monitoring of the World Health Organisation (WHO) and five steps to safer surgery checklist was not embedded across all relevant areas. This had improved at this inspection. The WHO checklists seen during inspection were completed and detailed.