

Norfolk and Norwich University Hospitals NHS Foundation Trust

Inspection report

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

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

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

Ratings

Overall rating for this trust

Inadequate 

Are services safe?	Inadequate 
Are services effective?	Requires improvement 
Are services caring?	Good 
Are services responsive?	Requires improvement 
Are services well-led?	Inadequate 

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

Summary of findings

Background to the trust

The Norfolk and Norwich University Hospital is an established 1,237 bedded NHS Foundation Trust which provides acute hospital care for a tertiary catchment area of up to 822,500 people.

The trust provides a full range of acute clinical services including more specialist services such as oncology and radiotherapy, neonatology, orthopaedics, plastic surgery, ophthalmology, rheumatology, paediatric medicine and surgery.

The status of foundation trust was achieved in May 2008. The trust is one of the largest teaching hospitals in the country. It operates from a large purpose built site on the edge of Norwich and from a smaller satellite at Cromer in North Norfolk. The hospital opened in late 2001, having been built under the private finance initiative (PFI). Cromer and District Hospital was rebuilt by the trust in 2012. Cromer Hospital offers surgical (day surgery and local anaesthetic only) and outpatient services (including a minor injuries unit and radiology department). Radiology outpatients at Cromer offers an appointment based GP referral service as well as a walk-in service for plain film, ultrasound and MRI.

The majority of patients live in Norfolk, North Suffolk and Waveney, however tertiary services are provided beyond these boundaries. The trust has the largest catchment population of any acute hospital in the East of England.

Between April 2016 and March 2017 there were:

- 159,430 Inpatient admissions
- 1,079,270 Outpatient attendances
- 126,861 accident and emergency attendances

As of , the trust employed 6,499 staff out of an establishment of 7,240, meaning the overall vacancy rate at the trust was 10%. The trust was in financial special measures between July 2016 and February 2017.

The trust's main clinical commissioning group (CCG) is NHS Norwich Clinical Commissioning Group. The trust has five commissioning groups in total.

The Trust is part in the Norfolk and Waveney Sustainability and Transformation Plan (STP). The NHSE STP progress assessment rated Norfolk and Waveney STP as 'advanced' (level 2). This triggered the release of additional funding for the STP, which was allocated to mental health.

We carried out a comprehensive inspection at Norfolk and Norwich University Hospital NHS Trust in November 2015 when the trust was rated as requires improvement overall. Urgent and Emergency care were rated as Good in the 2015 inspection and all other core services were rated as requires improvement.

A responsive inspection was then carried out in April 2017 due to a number of concerns that had arisen via our ongoing monitoring of the Trust alongside a number of whistle blowing contacts. We undertook focused inspections in medical care, surgery, maternity and gynaecology and services for children and young people. There were no overall service ratings attached to our findings for this inspection in respect of medicine, surgery or children and young peoples' services. Maternity and Gynaecology was rated as requires improvement.

We undertook a comprehensive inspection on 10 and 11 October 2017 with a follow up inspection on 23 October 2017. Core services inspected were urgent and emergency care, surgery, end of life care, outpatients and diagnostic imaging. We inspected services at Norfolk and Norwich Hospital only and the site at Cromer was not inspected. A well led inspection at provider level took place on 15 & 16 November 2017. Following some additional information of concern,

Summary of findings

received via whistle-blowers, we also undertook a number of unannounced inspections with regard to well led on 31 January 2018, 19 February 2018 and 21 February 2018. We undertook an unannounced inspection of the urgent and emergency department, the day procedure unit (DPU) and Edgefield ward on 22 March 2018 to follow up specific patient safety concerns.

Overall summary

Our rating of this trust went down since our last inspection. We rated it as Inadequate ● ↓

What this trust does

Norfolk and Norwich University hospitals NHS Trust provides a full range of acute clinical services across the following locations: Norfolk and Norwich University Hospital and Cromer Hospital.

At the time of inspection, the trust was in the process of deregistering the Henderson Unit, a 24-bedded health and social care reablement unit to help patients recover after a period of ill health.

Acute services are provided at Norfolk and Norwich University Hospital and encompass urgent and emergency care, planned medical and surgical care, critical care, maternity, neonatal and paediatric care, end of life care and diagnostic and therapy services. Including more specialist services such as oncology and radiotherapy, neonatology, orthopaedics, plastic surgery, ophthalmology, rheumatology, paediatric medicine and surgery.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

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

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

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

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse. Following the comprehensive inspection in 2015 we undertook enforcement action and told the trust it must take action to improve. CQC served two Requirement Notices; one in relation to Regulation 12, Health and Social Care Act (HSCA) (RA) Regulations 2014 Safe care and treatment. The other was in relation to Regulation 17 HSCA (RA) Regulations 2014 Good governance.

Following the responsive inspection in April 2017 we undertook enforcement action and told the trust it must take action to improve. CQC served two Requirement Notices; one in relation to Regulation 12, Health and Social Care Act (HSCA) (RA) Regulations 2014 Safe care and treatment. The other was in relation to Regulation 17 HSCA (RA) Regulations 2014 Good governance.

Between 10 October and 22 March 2018, we inspected the following core services; urgent and emergency care, surgery, end of life care, outpatients and diagnostic imaging services.

Summary of findings

We inspected the above services provided by this trust as part of our continual checks on the safety and quality of healthcare.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at the trust level. Our findings are in the section headed, is this organisation well-led?

What we found

Overall trust

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

Safe and well led were rated as inadequate, effective, and responsive were rated as requires improvement and caring was rated as good.

Our inspection of the core services covered Norfolk and Norwich Hospital only. Our decisions on overall ratings take into account, for example, the relative size of services and we use our professional judgement to reach a fair and balanced rating.

On the basis of this inspection, the Chief Inspector of Hospitals has recommended that the trust be placed into special measures.

Norfolk and Norwich Hospital

- Urgent and Emergency care was rated as inadequate overall. Safe, effective, caring and well led all went down, safe from requires improvement to inadequate. Effective from outstanding to requires improvement and caring from outstanding to good and well led went down from good to inadequate. Responsive went down from good to requires improvement. There were significant safety concerns within the department relating to premises, safety of patients with mental capacity concerns and infection prevention and control processes. We undertook immediate enforcement action in relation to the most significant concerns. The trust took the concerns seriously and responded appropriately with some immediate actions including a major redesign of the department and clinical decisions unit. Following whistle blower concerns we inspected again on 22 March 2018. At this inspection we found that the claims that the whistle blowers had made were substantiated. These included the number of patients waiting in corridors, delays in treatment, delays in admission of patients to beds on wards, an active policy of placing patients in trolleys on wards to await beds and manipulation of the delays through admitting patients who were approaching the 12 hour target rather than those who had already breached the target. However, we found that nurses and medical staff remained caring despite a low morale arising from not being able to provide the care they wanted to.
- Surgery was rated as inadequate overall. Safe and well led went down from requires improvement to inadequate, responsive stayed requires improvement and caring and effective remained good. Daily checks were not always carried out and mandatory training was below the trust's accepted target. There were concerns about the environment, equipment, medicines management and infection control procedures in the interventional radiology unit and the day procedure unit. The day procedure unit was utilised as an escalation area. The escalation criteria was not adhered to, with patients from multiple specialities admitted to this area, some with high level of acuity including palliative care patients and those living with dementia. Concerns were also raised by staff around the merge of vascular and urology specialties within Edgefield ward. Staff described training as adhoc and informal, staffing levels were not always in line with planned levels and we found gaps in monitoring of catheters, intentional rounding and completion of National Early Warning Score observations. People could not always access the surgical service as referral to treatment times and cancelled operations were not in line with national averages but were improving. Governance systems within the surgical service were not always embedded. However, the service monitored the effectiveness of treatment and staff cared for patients with compassion.

Summary of findings

- End of life care remained rated as requires improvement overall. Safe, effective and well led stayed requires improvement, responsive went down from good to requires improvement and caring remained good. The trust's 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms did not meet national standards and were not always completed correctly. There were lack of assurances that the Mental Capacity Act and Deprivation of Liberty Safeguards were always being implemented for people who had DNACPR documentation. There was a significant lack of syringe drivers in the trust, which impacted on patient care. However, the trust now provided a specialist palliative care service which was in line with national guidance, which was an improvement since the last inspection.
- Outpatients was rated as requires improvement overall. Caring was rated as good, safe, responsive and well led were rated as requires improvement. We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings. Staff were not always trained to the appropriate level for safeguarding children, records and medicines were not always stored correctly and waiting times from referral to treatment were not in line with good practice. However, there had been improvements in the quality of documentation in patient records and staff understanding of the incident reporting process.
- Diagnostic imaging was rated as requires improvement overall. Safe, responsive and well-led were rated as requires improvement and caring was rated good. We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings. Staff were not always trained to the appropriate level for safeguarding children, there were significant reporting backlogs and risks had not always been identified or addressed. However, there had been improvements in staff understanding of the incident reporting process and progress had been made in the recruitment of new staff.
- On this inspection we did not inspect medicine, critical care, maternity, gynaecology and children and young people services. The ratings we gave to these services on the previous inspection in the comprehensive inspection in November 2015 and responsive inspection in April 2017 are part of the overall rating awarded to the trust this time.

Are services safe?

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

- Urgent and Emergency care had gone down from requires improvement to inadequate for safety. The children's emergency department was not suitable for the service provided. The emergency department layout was not fit for purpose, it was widely spread, the area was not large enough to accommodate the potential number of service users using the department at any one time, and multiple areas within the department were not being used as intended or safely. There was a lack of safe, and secure where necessary, environments for those living with serious mental health concerns including those that were detained under the Mental Health Act (1983). Staff were not able to demonstrate sufficient understanding of the Mental Capacity Act (2005) nor that were they working within the requirements of this act. The healthcare records of patients were not always accurate. Infection prevention and control systems and processes were neither properly established nor operating effectively. We undertook enforcement action in relation to the significant concerns and the Trust took immediate actions to respond. At our inspection in March 2018 we found increased capacity pressures had increased risk to patient safety with staff reporting an increase in serious incidents, cohorting of patients in the emergency department corridor and significant waits, of several hours, to offload from ambulances at times of peak pressure.
- Surgery services had gone down from requires improvement to inadequate for safety. Significant concerns were identified in the environment of the induction and recovery area of the interventional radiology unit. There were, significant quantities of out of date consumables stored in this area. Patients with suspected infections were not being isolated appropriately in this area. We undertook an inspection on the 22 March 2018 in response to patient safety concerns, raised by whistle-blowers, in both the day procedure unit (DPU) and Edgefield ward. The day procedure unit was being utilised as an escalation area. The environment was unsuitable; the competency and skills of staff did not match the multispecialty patients that were admitted. These included patients with complex medical

Summary of findings

conditions, patients at the end of life and patients living with dementia. There was an increased risk to patient safety due to lack of equipment, medication omissions and difficulty in getting timely medical review. Patients were at risk of developing pressure sores and increased falls. Edgefield ward had been reconfigured to accommodate both urology and vascular specialties. Concerns included staffing, training, competency, and safety monitoring. Mandatory training for medical staff was significantly lower than the trusts target levels. Daily checks on resuscitation equipment and medicines were not always completed, especially within the theatre department. Across the service the resuscitation trolleys were not tamper proof although when raised with the trust new trolleys were ordered. In the theatre we saw that staff did not always comply with infection prevention and control policies in that staff were wearing rings and not covering their theatre wear when leaving the department. The service had four never events between June and November 2017, making a total of eight never events since February 2016. We were not assured that the learning from these were shared across the service in a consistent way. An additional never event was declared in the interventional radiology unit in March 2018, relating to wrong implant. This was despite two of the previous never events occurring in IRU which indicated a lack of embedded learning from the previous incidents. However, some areas were investigating incidents well and shared the learning from these.

- Services for end of life care remained requires improvement for safety. There was a significant lack of syringe drivers in the trust impacting on patient care. This was an issue identified at the 2016 inspection. Four hourly syringe driver checks were not consistently completed. However, the service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Staffing level for the specialist palliative care team (SPCT) was in line with national guidance and staff were up to date with mandatory and safeguarding training.
- Outpatients was rated as requires improvement for safety. Outpatient staff were not always trained to the appropriate level for safeguarding children and there was low compliance in some areas of mandatory training. Records were not always stored securely and medicines were not always stored appropriately in outpatient areas. Incidents were not always reported and investigations not always completed in a timely manner.
- Diagnostic imaging was rated as requires improvement for safety. Diagnostic imaging staff were not always trained to the appropriate level for safeguarding children and there was low compliance in some areas of mandatory training. Equipment was ageing with no capital replacement programme in place and specialist personal protective equipment was not always checked appropriately. Security and access to controlled areas was not consistent. Contrast media was not stored appropriately. The emergency patient call bell system within nuclear medicine had not been fit for purpose since 2015.

Are services effective?

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

- Urgent and Emergency care had gone down from outstanding to requires improvement for effective. Staff throughout the service were not able to demonstrate sufficient understanding of the Mental Capacity Act (2005), Mental Health Act (1983) and Deprivation of Liberty Safeguards (DoLS). This meant that mental capacity assessments were not being carried out where required. Appraisal compliance was poor and there was a lack of oversight of local audit to drive improvements. However patient outcomes were generally good in relation to Royal College of Emergency Medicine audit results and CQUIN data on sepsis. Staff worked together as a team to benefit patients.
- The Surgery service remained good for effective. Policies and procedures were in line with national guidance and the service monitored the outcomes of the service. Staff undertook training to ensure that they were competent to carry out their roles. Staff recognised the importance of ensuring that patients were fed and hydrated and knew how to adapt to ensure that they met their needs. Staff knew how to respond appropriately to the needs of people who may lack capacity or who were vulnerable. There was good multidisciplinary working with staff within and external to the service.

Summary of findings

- Services for end of life care remained requires improvement for effective. The 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms did not meet national standards and were not always completed correctly. There was lack of evidence that Mental Capacity Act and Deprivation of Liberty Safeguards were always implemented for people who had DNACPR documentation. This issue was highlighted at the 2016 inspection. However, the care provided was in line with national guidance, documentation had been revised and individualised care plans introduced. The specialist palliative care team (SPCT) provided a seven-day service, which was an improvement from the last inspection
- We do not currently rate the effectiveness of outpatient services. Policies were aligned to national guidance and audits were being carried out to monitor compliance and identify service improvements. Staff of different kinds worked together as a team to benefit patients. However, appraisal rates were below the trust target and audit action plans were not always robust.
- We do not currently rate the effectiveness of diagnostic imaging services. Appraisal rates were in line with trust targets and the service offered staff the opportunity for development and progression in their roles. The service was regularly reviewing the effectiveness of care and treatment through a comprehensive range of audits. However, the diagnostic imaging service was not always meeting NHS England *Seven Day Services Clinical Standards* and audit action plans were not always robust.

Are services caring?

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

- Urgent and Emergency care had gone down from outstanding to good for caring. Staff took the time to interact with patients, act in a caring manner and be exceptionally kind to patients and those close to them. Results from the Friends and Family Tests for the service were consistently good. Patients and relatives felt involved and there was a range of emotional support available. However, we did observe two episodes of care where staff attended to patients in an uncaring manner. There was a high security presence within the department. Security guards were intimidating in manner and we witnessed these staff acting in a highly disrespectful way that was not challenged by staff in the department. We raised this at the time of inspection and although these staff were not directly employed by the trust they were aware of this and were working with the providing company to address how security staff managed challenging behaviour which may have a medical origin.
- Surgery remained good for caring. Surgical staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Staff involved patients and those close to them in decisions about their care and treatment. Staff provided emotional support to patients to minimise their distress. Staff within the day procedure unit were passionate about providing the best care possible for patients and were visibly upset when this could not be achieved.
- Services for end of life remained good for caring. Both medical and nursing staff treated their patients receiving end of life care, and their families, in a sensitive manner. Dignity and respect was embedded across all disciplines of staff including nurses, doctors, chaplains and porters. Individualised care plans included psychological and spiritual needs.
- Outpatient services were rated good for caring. Staff took the time to interact with patients in a respectful and considerate manner and were supportive and reassuring. Patients provided positive feedback about the care provided by staff, who they described as kind and caring. However, patients did not always have privacy when being weighed or when speaking to a receptionist.

Summary of findings

- Diagnostic imaging services were rated good for caring. Patients gave consistently positive feedback about the care provided by staff and we observed kind and caring interactions between patients and staff. However, Friends and Family Test scores were below the national average and the environment did not always afford patients with privacy and dignity.

Are services responsive?

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

- Urgent and Emergency care had gone down from good to requires improvement for responsive. People could not always access the service when they needed it. Performance metrics, whilst improving, remained below the national average in October 2017. In March 2018 we found that delays in treatment had significantly deteriorated. In February 2018 only 56% of patients were treated within four hours against a national performance of 77%. Lessons learnt from complaints were not demonstrable. However, the staff had developed some innovative pathways to help improve access and flow in response to the requirements of the local population for example, due to a high number of frail and elderly patient's attending the ED, the service had specific frail and elderly pathways in place.
- Surgery remained requires improvement for responsive. People could not always access the service when they needed it. The trust's referral to treatment time for admitted surgical pathways was consistently worse than the England average, although there was an improving picture between April and June 2017. The number of patients who had their operations cancelled was also above the national average however this was an improving picture since the previous comprehensive inspection. The recovery area was still being used for patients who required high dependency care. The facilities and premises for the interventional radiology unit were insufficient to meet demand. Complaints were not always responded to in line with the trusts policy. However, staff tried to meet the needs of individual patients and were working with others to create new enhanced surgical pathways.
- Services for end of life remained requires improvement for responsiveness. Monitoring of preferred place of care (PPC) and preferred place of death (PPD) was not embedded and the number of patients that received their PPC / PPD was low. There was no formal monitoring of fast track discharge. However visiting hours were flexible to ensure relatives could spend as much time as needed with their loved ones. Complaints relating to end of life care were reviewed by the specialist palliative care team (SPCT) and discussed at the clinical governance meeting. Where themes in complaints around end of life care was found, areas of learning were identified and changes implemented.
- Outpatient services were rated as requires improvement for responsiveness. Waiting times from referral to treatment were not in line with good practice. The trust did not monitor clinic waiting times but patients told us that clinics frequently ran behind time. A high number of clinics were cancelled at short notice. However, outpatient specialties offered some out-of-hours appointments, one-stop clinics, community based appointments, and telephone appointments, which provided patients with flexibility and choice.
- Diagnostic imaging services were rated as requires improvement for responsiveness. There were significant waiting lists for diagnostic imaging services and waiting times for the completion of scans did not always meet internal targets. Reporting times were not meeting targets in the majority of diagnostic imaging areas. The facilities and premises for the catheter labs were insufficient to meet demand. However, the service took account of patients' individual needs and offered out of hours, walk-in and one stop services to provide flexibility and choice.

Are services well-led?

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

- Urgent and Emergency care had gone down from good to inadequate for well led. Whilst there was a strategy in place we found an abundance of evidence whereby staff locally have continued to raise concerns to senior hospital managers, about safety issues and the lack of progress to make improvements. The implementation of learning from

Summary of findings

incidents was not always robust. The senior leadership team had not taken actions to address the significant concerns in the service until we raised them and had failed to address a number of concerns that were highlighted during our previous inspection in 2015. There was a lack of grip and oversight over access and flow in the emergency department.

- Surgery went down from requires improvement to inadequate for well led. Governance systems within the service were not embedded, including infection prevention and control practices, safeguarding policy, the safe management of medicines and the theatre dress code. New theatre governance processes that we were informed about on our April 2017 inspection had yet to be implemented and processes in place to replace equipment were not timely. There remained a disconnect between staff in theatre in sharing the lessons learnt from the never event to enhance practice throughout the department. Whilst staff spoke highly of their line managers there was criticism about the way in which information about recent ward moves had been communicated. There was a lack of oversight of risks in several areas including the induction and recovery area of the interventional radiology unit, the day procedure unit and Edgefield ward. Staff felt ignored and unsupported when raising concerns.
- Services for end of life remained requires improvement for well led. A named non-executive director (NED) was not in place for end of life care, which was highlighted at the last inspection. There were some risks identified by the SPCT that were not included in the divisional risk register, including the lack of syringe drivers in the trust. However, the trust had an end of life care strategy in place which referenced key national guidance and included defined local priorities, outcomes and measures of success. The trust engaged with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- Outpatient services were rated requires improvement for well led. There was limited ongoing monitoring of performance in the outpatient service and there was no long-term vision or strategy. Outpatients sat across the four clinical divisions which meant there was no overall lead for outpatient services and inconsistencies in oversight across the various specialities. The service did not always effectively plan to eliminate risks; 44% of outpatient risks had been on the risk register for over four years. However, leaders had the skills, knowledge and experience that they needed and they understood the challenges to quality and sustainability. There was a positive culture and staff said that they felt supported, respected and valued.
- Diagnostic imaging services were rated requires improvement for well led. Managers had not identified or put in place actions to address a number of the concerns that were identified during our inspection. Action had not been taken to address some of the concerns identified at our previous inspection. Risks were not always resolved or acted upon in a timely manner and the risk register did not reflect all of the risks identified during this inspection. However, staff said that managers were supportive, they felt proud to work for the organisation and the majority of staff were aware of the trust values. Strategic goals had been identified for the service and these were reviewed on an ongoing basis.
- Overall the trust was rated as inadequate for well led. In our previous report, November 2015, we had raised concerns regarding the bed management and site management processes and culture between the operational and clinical teams and reported that the trust should make improvements. We found that no significant changes or improvement had been made. The culture between the site management team and nursing team was not one of mutual respect. Capacity and target pressures meant that the board remained too operationally focussed and reactive. Patient safety concerns raised by the clinical nursing teams were not openly received, or taken into account, which meant decisions around access and flow were not always weighted appropriately to ensure the risk to patients was as low as possible. Some nursing and medical staff felt unsupported by the senior management team and rarely saw them in wards and departments even in times of increased pressure.

A cohesive strategic plan for access and flow was lacking. Whilst a winter escalation policy and procedure were in place, senior nursing staff were not aware and clinical input and learnings from last winter had not been incorporated.

Summary of findings

Protocols put in place were not patient focused and impacted negatively on patient safety. Whilst the trust had implemented some initiatives to improve the culture of the organisation since 2015, such as an anonymous contact line and speak up guardians we found that there remained a fear amongst staff, at all levels, that raising concerns could not be safely undertaken without fear of reprisals.

In November 2017 the trust had a complete executive team with six substantive executive directors in place. The longest standing member of the executive team had been in post since December 2012 with the most recent appointment taking place in January 2017. This was an improvement from the previous inspection and initially appeared to provide stability. However, we found there had been very limited development of individuals and no structured support to learn from the previous bullying culture that had been experienced by the long-standing members of the team to enable a cohesive team in an open and transparent culture.

In the external report, dated October 2017, it had been recognised that the executive team should reflect on their personal and collective development. We were informed that the team were about to begin a development programme, initial reflection and preliminary exercises had taken place however the developmental day had been cancelled and was yet to be rearranged. Following our unannounced inspection on 31 January 2018 we were informed this had been rescheduled for February 2018.

We found there was inconsistency in line management processes of the executive team members. A perceived “inner circle” had hindered the ability of the team to function together and in January 2018 two of the executive team members, the director of nursing and chief of finance, left the trust.

Ratings tables

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

We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly. However, we used the information gained in the comprehensive inspection in order to inspect these services at this inspection.

Outstanding practice

We found examples of outstanding practice in urgent and emergency care, outpatients and diagnostic imaging services.

For more information, see the Outstanding practice section of this report.

We found the following outstanding practice:

- Pathways for the management of stroke and fractured neck of femur were impressive. The urgent and emergency service worked with the trust’s specialist teams, at times in the ambulance bay, to assess and treat patients quickly and effectively as possible.
- The urgent and emergency service had recently appointed 15 Assistant Clinical Practitioners (ACPs), of which four had completed the course and were working within the service and six further were due to complete their course soon. One ACP was allocated to children’s ED entirely. The ACP role assisted the medical rota.
- The cardiology outpatients’ department had set up a physiotherapy cardiology breathing pattern disorder clinic in response to an identified patient need and had produced significantly improved patient outcomes.

Summary of findings

- A forum for outpatient staff had been established in 2017 and this had provided an opportunity for staff to network and communicate across divisions, grades and specialties. Staff had explored shared issues and set up project groups to resolve these. The forum had improved engagement with the executive team, who had attended meetings and taken part in open discussions with staff.
- Some outpatient areas were offering innovative treatments. For example, the dermatology outpatient area offered the gold standard treatment for basal cell carcinoma (BCC), known as Mohs surgery. This procedure allows for the removal of all cancerous cells for the highest cure rate whilst sparing healthy tissue and leaving the smallest possible scar. Gastroenterology were due to implement an innovative new faecal matter transplant treatment for patients with C difficile.
- The radiology department won a Health Enterprise East (HEE) award for an innovation designed to benefit patients in the service improvement category for their work on reducing the number of appointments missed through patients not attending. The department used targeted text messaging via a system on the hospital's intranet, to patients who were due to attend a radiology appointment within the next 48 hours. The project reduced the "Did Not Attend" (DNA) rate from 5% to 3.1%.

Areas for improvement

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

On the basis of this inspection, the Chief Inspector of Hospitals has recommended that the trust be placed into special measures.

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

Action we have taken

We issued one warning notice under section 29A of The Health and Social Care Act 2008 in relation to significant concerns in the urgent and emergency care service. The trust was required to make significant improvements by 1 January 2018. The trust has provided CQC with action plans in response to the warning notice and has updated CQC as to the timely progression of these plans.

We sent a serious concerns letter to the trust on 31 October 2017 outlining our concerns relating to patient restraint. The trust provided a response to the individual concerns in the letter and provided an action plan to address the recommendations identified. These included a named lead for Reduction of Restrictive Intervention (RRI), development of an RRI strategy and protocol, review of policy, clear reporting and performance monitoring measures and staff training.

We issued six requirement notices to the trust. That meant the trust had to send us a report saying what action it would take to meet these requirements. Our action related to breaches of in a number of core services.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

What happens next

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

Outstanding practice

Summary of findings

We found examples of outstanding practice in urgent and emergency care, outpatients and diagnostic imaging services.

We found the following outstanding practice:

- Pathways for the management of stroke and fractured neck of femur were impressive. The urgent and emergency service worked with the trust's specialist teams, at times in the ambulance bay, to assess and treat patients quickly and effectively as possible.
- The urgent and emergency service had recently appointed 15 Advanced Clinical Practitioners (ACPs), of which four had completed the course and were working within the service and six further were due to complete their course soon. One ACP was allocated to children's ED entirely. The ACP role assisted the medical rota.
- The cardiology outpatients' department had set up a physiotherapy cardiology breathing pattern disorder clinic in response to an identified patient need and had produced significantly improved patient outcomes.
- A forum for outpatient staff had been established in 2017 and this had provided an opportunity for staff to network and communicate across divisions, grades and specialties. Staff had explored shared issues and set up project groups to resolve these. The forum had improved engagement with the executive team, who had attended meetings and taken part in open discussions with staff.
- Some outpatient areas were offering innovative treatments. For example, the dermatology outpatient area offered the gold standard treatment for basal cell carcinoma (BCC), known as Mohs surgery. This procedure allows for the removal of all cancerous cells for the highest cure rate whilst sparing healthy tissue and leaving the smallest possible scar. Gastroenterology were due to implement an innovative new faecal matter transplant treatment for patients with C difficile.

Detailed evidence and data supporting our judgements is provided in the evidence appendix.

Areas for improvement

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

Action the trust **MUST** take to improve

We told the trust that it must take action to bring services into line with legal requirements. This action related to services and the trust overall. The services were urgent and emergency care, end of life care, outpatients and diagnostic imaging services.

For the overall trust:

- The trust must ensure that mandatory training attendance improves to ensure that all staff are aware of current practices.
- The trust must review the knowledge, competency and skills of staff in relation to the Mental Capacity Act and Deprivation of Liberty safeguards.
- The trust must ensure that staff annual appraisal completion improves.
- The trust must ensure that there is an effective process for quality improvement and risk management in all departments.

Summary of findings

- The trust must ensure that local audit findings are utilised to identify actions for improvement and that these are monitored, and reviewed.
- The trust must review the bed management and site management processes within the organisation to increase capacity and flow and ensure effective formalised processes are in place to ensure patient safety in all escalation areas.
- The trust must improve the relationship and culture between the site management team and the senior nursing and clinical teams to ensure open dialogue where patient safety is equally weighted to operational pressure to reduce risk to patients and staff.
- The trust must embed the recently formalised processes for review and assessment of escalation areas to reduce the risk to patient safety.
- The trust must review process for whistleblowing and take definitive steps to improve the culture, openness and transparency throughout the organisation.
- The trust must improve the functionality of the board and ensure formalised processes are in place for the development and support of both current and new executive directors.
- The trust must ensure consistency processes are in place for recruitment, fit and proper person's regulation and line management at executive level.
- The trust must improve the level of oversight, scrutiny and challenge from the chair and non-executive directors (NEDS).

In Urgent and Emergency services:

- The trust must ensure that action plans are monitored and that action is taken following the investigation of serious incidents.
- The trust must ensure that there are effective systems and processes in place to ensure assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are healthcare associated.
- The trust must ensure that staff compliance with mandatory training improves significantly. This includes basic life support, paediatric life support, Mental Capacity Act (2005), Deprivation of Liberty Safeguards (DoLS), prevention and management of aggression (PMA), and infection, prevention and control training.
- The trust must ensure staff compliance improves for major incident training.
- The trust must ensure that the premises for urgent and emergency services protect patients from potential harm and used for the intended purpose. This includes all areas of the service for both children and adults.
- The trust must ensure that there is a system in place, which is adequately resourced, to ensure that patients are assessed, treated and managed in a time frame to suit their individual needs.
- The trust must action its plans to expand the children's and adults emergency department, including the provision of a high dependency unit for children outside of the resuscitation department.
- The trust must review its nursing and medical staffing numbers for the urgent and emergency services and plan staffing acuity accordingly.
- The trust must ensure that there is one registered children's nurse at all times within the children's emergency department and take necessary action to increase the number of registered children's nurses employed.
- The trust must ensure a good skill mix within the children's ED nursing workforce.

Summary of findings

- The trust must ensure audio and visual separation between adults and children being assessed and waiting within the emergency department and minor injuries unit.
- The trust must ensure that there are a sufficient number of environments which protect patients from potential harm within the urgent and emergency service, for the assessment and treatment of patients living with mental health concerns, including those who are detained under the Mental Health Act (1983).
- The trust must ensure emergency equipment, including ligature cutters and children's resuscitation equipment is readily available.
- The trust must ensure that oxygen cylinders are stored safely, that oxygen is readily available in all patient areas, and that this equipment is properly maintained.
- The trust must ensure that patient venous thromboembolism (VTE) risk assessments are completed.
- The trust must ensure that necessary risk assessments and healthcare records are complete for mental health patients.
- The trust must ensure that computers are locked and that patient healthcare records are stored securely.
- The trust must improve staff compliance with level three children's safeguarding training.
- The trust must improve its performance times in relation to national time of arrival to receiving treatment (which is no more than one hour), four-hour target and monthly median total time in A&E.
- The trust must ensure that there is a medical lead appointed for the service.
- The trust must ensure that mental capacity assessments are carried out for all patients who lack mental capacity, ensuring appropriate patient care plans are in place accordingly.
- The trust must ensure that the healthcare records for patients' subject to restraint are complete and in line with the trust's policy and procedure.
- The trust must ensure that there is a local audit programme in place for the service, that action plans are in place and necessary improvements are made to practice following audit.
- The trust must ensure that lessons learnt from concerns and complaints are used to improve the quality of care.
- The trust must ensure that patients are treated with dignity and respect at all times.

In Surgery:

- The trust must ensure that staff caring for children in the recovery area have appropriate level safeguarding training in line with national guidance and trust policy.
- The trust must ensure that safeguarding training compliance for both medical and nursing staff improve in line with the trust's targets.
- The trust must ensure temperature charts for blood and medicine fridges are appropriately completed and records held in line with national requirements.
- The trust must ensure that the environment, equipment storage, medicines management and infection control procedures are appropriate in the interventional radiology unit.
- The trust must ensure that leadership, culture and behaviours within the operating theatre department are actively addressed.

Summary of findings

- The trust must ensure that there is effective governance, safety and quality assurance processes within the theatre department that are structured, consistent, and monitored to improve practice and reduce risk to patients.
- The trust must ensure that the World Health Organisation (WHO) and five steps to safer surgery checklist is completed appropriately, and that learning from incidents and regular monitoring processes become embedded to empower staff to challenge and report any poor practice.

In End of Life Care:

- The trust must review 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms to ensure they are completed fully and in line with trust policy and national guidance.
- The trust must review its Mental Capacity Assessment and Deprivation of Liberty Safeguarding process and the way this is documented within patients' notes.

In Outpatients:

- The trust must ensure that incidents are reported and investigated in a timely way by trained investigators.
- The trust must ensure that medicines are stored securely and in line with national guidance.
- The trust must ensure that equipment is maintained and fit for use.
- The trust must ensure staff complete appropriate mandatory training including safeguarding training to a level appropriate to their job role.
- The trust must ensure that patient records are stored securely.
- The trust must ensure that there is an effective process for quality improvement and risk management.

In Diagnostic Imaging services:

- The trust must ensure that medicines and contrast media are stored securely and in line with national guidance.
- The trust must ensure staff complete appropriate mandatory training including safeguarding training to a level appropriate to their job role.
- The trust must ensure that resuscitation equipment is checked in accordance with trust policy.
- The trust must ensure that incidents are investigated in a timely way.
- The trust must ensure that observational audits of the quality of the World Health Organisation (WHO) and five steps to safer surgery checklists are undertaken.
- The trust must ensure that specialist personal protective equipment, such as the integrity of lead aprons, is checked on a regular basis.
- The trust must ensure that the call bell system within nuclear medicine is fit for purpose.
- The trust must ensure that there is an effective process for quality improvement and risk management.

Action the trust SHOULD take to improve

We told the trust that it should take action either to comply with a minor breach that did not justify regulatory action, to avoid breaching a legal requirement in future or to improve services. This action related to urgent and emergency care, services for children and young people, end of life care, medical services and community inpatient services.

For the overall trust:

Summary of findings

- The trust should ensure that regular review of the executive portfolio takes place to ensure capacity and capability to deliver requirements.
- The trust should review the support managers provide to support staff in times of increased demand.

In Urgent and Emergency services:

- The trust should ensure that staff carrying out Root Cause Analysis (RCA) investigations for serious incidents receive appropriate RCA training.
- The trust should ensure that staff carrying out Duty of Candour applications receive appropriate training.
- The trust should ensure that regular and minuted mortality and morbidity meetings take place for urgent and emergency services.
- The trust should ensure that a safety thermometer is implemented for children's and adult urgent and emergency services.
- The trust should ensure that sepsis training is available to all staff providing urgent and emergency care.
- The trust should review its e-learning system to ensure staff can access training programmes.
- The trust should review its use of the Rapid Assessment and Treatment (RAT) system and ensure this is embedded into practice.
- The trust should review its communication aids available to assist staff to communicate with patients living with a sensory loss, such as hearing loss.

In Surgery:

- The trust should continue to monitor and improve referral to treatment time in line with national standards.
- The trust should continue to monitor and actively recruit to ensure that there is an adequate number of nursing staff with the appropriate skill mix to care for patients in line with national guidance.
- The trust should ensure that both medical and nursing mandatory training compliance is improved in line with trust targets.
- The trust should ensure that effective processes are in place for correct handling and disposal of clinical waste, including sharps bins, and that storage of chemicals is secure in line with the Control of Substances Hazardous to Health (COSHH) guidelines.
- The trust should ensure that theatre staff adhere to the dress code policy.
- Ensure complaints are responded to in line with the complaints policy deadline of 25 working days.
- The trust should ensure morbidity and mortality meeting minutes include sufficient detail of background information, discussions and those in attendance.
- The trust should ensure that specialist personal protective equipment is checked on a regular basis and worn appropriately by staff.

In Outpatients:

- The trust should ensure that the management of referrals into the organisation reflects national guidance in order that the backlog of patients on an 18-week pathway are seen.
- The trust should ensure that there is ongoing monitoring of the outpatient service, including the re-development of an outpatient dashboard.

Summary of findings

In Diagnostic Imaging services:

- The trust should ensure effective processes are in place for the timely completion of diagnostic reports.
- The trust should ensure that diagnostic imaging equipment remains fit for use through the implementation of a capital replacement programme.
- The trust should ensure that diagnostic imaging services are provided on a seven-day basis, in line with national guidance.

For more information, see sections on individual services and on Regulatory action.

Is this organisation well-led?

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

We rated well-led at the trust as inadequate because:

- There were divisions within the executive team and the team was not functioning effectively or cohesively. Working relationships had fractured and led to some episodes of inappropriate behaviour. A perceived inner circle had contributed to a lack of open and transparent communications amongst the executive team.
- There had been limited and inconsistent formal development of the executive directors, either individually or collectively. There was evidence of inconsistent line management and recruitment processes. Support within the executive team was informal and selective, with no strategy developed to learn from the culture that was previously reported in March 2015.
- There was a lack of progress in addressing areas of improvement identified at previous inspections. Having raised the concerns in the emergency department and interventional radiology at this inspection the senior team undertook immediate action to address these issues. However, the rationale for the delay in addressing these issues was not clear in all instances.
- There was a lack of clinical staff empowerment. There remained a divide between operational and clinical teams, with the culture between site management and senior clinical staff remaining a concern. Capacity and target pressures meant that priority was operational rather than focussed on reducing risk and ensuring patient safety.
- There was evidence, through whistle blowers and our findings on inspection that a bullying culture remained at the trust. We found that there remained a culture of fear and reprisal amongst staff if they should raise concerns.
- We found significant clinical risk and patient safety concerns that the executive team were not aware of. In addition, when staff raised patient safety concerns there was a lack of response by the senior team.
- We found concerns in the leadership of several of the core services across the trust. Poor practice in certain core service areas had become normalised practice.
- Whilst it had been recognised that team development and review of individual capacity and capability to support delivery of portfolios was required this had not been undertaken in a timely manner.

Summary of findings

- Oversight by the chair and non-executive directors of the functioning of the executive team was not effective. They felt the trust had an improved culture and a stable team and they were surprised by the concerns we raised about leadership and patient safety.
- Whilst the trust responded to concerns raised by us throughout inspection they were not identifying and addressing these internally, which meant risk assessment and quality assurance processes were not fully effective, and challenge was not rigorous.

However

- The divisional structure was beginning to embed with information flows improving between those managing divisions and senior leaders. Divisional leaders felt empowered to make changes to their services and received support from senior leaders to improve the services they offered.
- Senior leaders were aware of the wider capacity risks to the organisation and the challenges it faced. They were proactively working with other stakeholders to improve services for the local community and the sustainability and transformation plan working group.
- Senior leaders were responsive to the issues brought to their attention following our inspection. Immediate action was taken to address the issues raised within the Emergency department and within diagnostic imaging. The senior leaders ensured that the local CQC team were aware of future plans and action taken.
- The trusts 'Excellence Together' programme was launched in March 2017 and whilst this is having some initial good results it requires embedding. There were various staff recognition schemes in place across the organisation, such as inclusion in the monthly "viewpoint" publication and the PRIDE awards ceremony.

Ratings tables

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

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Inadequate ↓ Jun 2018	Requires improvement ↔ Jun 2018	Good ↔ Jun 2018	Requires improvement ↔ Jun 2018	Inadequate ↓ Jun 2018	Inadequate ↓ Jun 2018

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

Ratings for Norfolk and Norwich hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate ↓ Jun 2018	Requires improvement ↓↓ Jun 2018	Good ↓ Jun 2018	Requires improvement ↓ Jun 2018	Inadequate ↓↓ Jun 2018	Inadequate ↓↓ Jun 2018
Medical care (including older people's care)	Requires improvement Aug 2017	Good Mar 2016	Good Mar 2016	Requires improvement Aug 2017	Requires improvement Aug 2017	Requires improvement Aug 2017
Surgery	Inadequate ↓ Jun 2018	Good ↔↔ Jun 2018	Good ↔↔ Jun 2018	Requires improvement ↔↔ Jun 2018	Inadequate ↓ Jun 2018	Inadequate ↓ Jun 2018
Critical care	Requires improvement Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Maternity	Requires improvement Aug 2017	Requires improvement Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Requires improvement Aug 2017
Services for children and young people	Requires improvement Aug 2017	Good Mar 2016	Good Mar 2016	Good Aug 2017	Good Aug 2017	Good Aug 2017
End of life care	Requires improvement ↔↔ Jun 2018	Requires improvement ↔↔ Jun 2018	Good ↔↔ Jun 2018	Requires improvement ↔↔ Jun 2018	Requires improvement ↔↔ Jun 2018	Requires improvement ↔↔ Jun 2018
Outpatients	Requires improvement Jun 2018	Not rated	Good Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018
Diagnostic imaging	Requires improvement Jun 2018	Not rated	Good Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018
Overall*	Inadequate ↓ Jun 2018	Requires improvement ↔↔ Jun 2018	Good ↔↔ Jun 2018	Requires improvement ↔↔ Jun 2018	Inadequate ↓ Jun 2018	Inadequate ↓ Jun 2018

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

Norfolk and Norwich University Hospital

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Key facts and figures

The Norfolk and Norwich University Hospital is an established 1,237 bedded NHS Foundation Trust which provides acute hospital care for a tertiary catchment area of up to 822,500 people.

The trust provides a full range of acute clinical services including more specialist services such as oncology and radiotherapy, neonatology, orthopaedics, plastic surgery, ophthalmology, rheumatology, paediatric medicine and surgery. Services are provided 24 hours a day, seven days a week.

The majority of patients live in Norfolk, North Suffolk and Waveney, however tertiary services are provided beyond these boundaries. The trust has the largest catchment population of any acute hospital in the East of England.

Between April 2016 and March 2017 there were:

- 159,430 Inpatient admissions
- 1,079,270 Outpatient attendances
- 126,861 accident and emergency attendances

As of , the trust employed 6,499 staff out of an establishment of 7,240, meaning the overall vacancy rate at the trust was 10%. The trust was in financial special measures between July 2016 and February 2017.

During this inspection we spoke with 226 members of staff including, but not limited to, doctors, nurses, support workers, administrative staff, pharmacists, allied health professionals, operations staff, advanced clinical practitioners, senior managers and members of the executive team. We spoke with 50 patients, relatives and carers and reviewed 70 sets of patient records.

Acute Services

Norfolk and Norwich Hospital

What we found is summarised above under the sub-heading Overall trust.

Urgent and emergency services

Summary of findings

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

- As with emergency departments (ED) throughout the NHS, the trusts ED was struggling to cope with the numbers of people attending the department due to the winter pressures. At the time of our initial inspection the planned new paediatric ED and the older persons ED were not open and this meant that the department continued to treat paediatric patients in an environment that was no longer fit for purpose and safe for children to receive care. When we returned in March 2018 we found that these areas were open but that the older persons ED was staffed by the main ED after 5pm increasing pressure within the main ED.
- The leaders within the organisation were slow to respond to previously identified concerns and had not maintained adequate risk assessment, governance and oversight within the department to ensure that patients were protected from potential harm.
- Action plans for Root Cause Analysis (RCA) investigations were not monitored or kept up-to-date. We were told by senior managers carrying out RCA investigations that they had not received RCA training or training on Duty of Candour. However, the trust informed us that staff who undertook duty of candour had received appropriate training.
- Within the ED we found a number of issues which require improvement including infection control processes, equipment was not always stored appropriately, records were not always robust and at times the number of staff on duty did not meet patient safety needs.
- At our inspection in October 2017, the environment for those living with serious mental health concerns including those that were detained under the Mental Health Act (1983) did not always mitigate the risk of harm to these patients or staff. Following us raising this with the trust they undertook remedial action to mitigate these risks. Following the relocation of the paediatric ED in January 2018, the trust began a development programme to provide an area for the assessment and treatment of patients with mental health illnesses in the space available. Significant gaps identified in the healthcare records of mental health patients. Staff throughout the service were not able to demonstrate sufficient understanding of the Mental Capacity Act (2005), Mental Health Act (1983) and DoLS.
- Infection, prevention and hygiene had deteriorated since our last inspection, there were concerns with the environment, particularly within the children's department and staff training compliance for infection prevention and control was poor.
- Multiple areas throughout the service were not being used as intended. We found that there were no security restrictions in place when entering the children's ED, however the trust responded immediately and had taken appropriate action by our follow up inspection visit on 23 October 2017. When we returned in March 2018 we found that the new paediatric ED was secure.
- Staff's mandatory training and safeguarding compliance was significantly below the trust's target. For example, only 54% of medical staff had completed their mandatory training. Only 66% of nurses and 68% of medical staff had completed level three safeguarding training.
- The ED did not always use the information it collected to identify areas for improvement. This included audit results, complaints and incidents.
- At times of peak pressure, patients were being cohorted in the emergency department corridor and substantial waits, at times over seven hours; to offload from ambulances were compromising patient care.

However:

- Staff within the ED were cognisant of the importance of reporting safety and safeguarding concerns.
- The Older Persons Emergency Department is the first dedicated older person's ED in the country.

Summary of findings

- There was a clear streaming process in place which meant that patients arriving at the ED were assessed quickly and directed to the most appropriate department.
- The service planned and delivered services as best as they could, given the capacity and staffing restraints they faced. They developed innovative ways to ensure the service was as responsive as possible. This included a number of admission avoidance schemes and pathways that had been developed so as patients could be admitted quickly to specialist areas within the hospital.
- Medicines management in general was good. The service had taken appropriate action following our last inspection in November 2017 to ensure triage nurses were competent to administer medication via patient group directives (PGD).
- There were numerous patient pathways in place which reflected current evidence-based practice and national standards.
- Managers for the service had taken appropriate action in relation to the concerns we raised in November 2015 about poor attitude between nursing and medical staff. Staff, teams and services worked together exceptionally well to ensure the delivery of effective care and treatment.

Surgery

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

- Resuscitation trolleys, medicines fridges and ambient air temperature in medication rooms were not being checked daily.
- The resuscitation trolleys were not tamper proof.
- A range of concerns were identified with the environment, equipment, medicines management and infection control procedures in the interventional radiology unit and day procedure unit.
- The day procedure unit was routinely being utilised as an escalation area. An admission criterion was not adhered to, staffing numbers and competency did not match the multi-specialty complex patients that were admitted to the area. A checklist for in patient quality rounds for escalation areas had been introduced but these were not consistently completed.
- Staff in recovery did not have safeguarding level 3 despite caring for children.
- Doctors safeguarding training was far below the trust target of 90% with 73% for adults and 63% for children.
- Mandatory training levels were below the trust target of 90%.
- The service had four never events between June and November 2017, making a total of eight never events since February 2016. An additional never event had occurred in the interventional radiology department in March 2018 (making three in total for IRU). We were not assured that any actions to reduce the risk of reoccurrence or shared learnings were consistent or effective. The two most recent never events, occurring in theatre, directly involved failings in ensuring the World Health Organisation (WHO) and five steps to safer surgery checklist was completed appropriately.
- We identified infection prevention and control issues with sharps waste management and adherence to the theatre dress code.
- Processes in place to report faulty equipment were not effective and a faulty blood fridge remained in use within theatres.

Summary of findings

- The trust's referral to treatment time for admitted surgical pathways was consistently worse than the England average, although there was an improving picture between April and June 2017.
- There was a lack of oversight of the induction and recovery area of the interventional radiology unit with no clear leadership, accountability or responsibility for this area.

However:

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.
- The trust had effective systems in place for the implementation and monitoring of national guidelines.
- Staff treated patients with compassion, dignity and respect. Feedback from patients confirmed that staff treated them with kindness.
- Staff involved patients and those close to them in decisions about their care and treatment. Patient feedback confirmed that they felt they had an active role in their treatment and that all treatment had been explained in a way that they could understand.

End of life care

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

- There was a significant lack of syringe drivers in the trust, which impacted on patient care.
- There were some inconsistencies in adhering to the four hourly syringe drivers checks, as per trust policy.
- The trust's 'do not attempt cardio-pulmonary resuscitation' forms did not meet national standards and were not always completed in line with national standards or the trusts own policy. We were not assured that the Mental Capacity Act and Deprivation of Liberty Safeguards were always implemented for people who had do not attempt cardio pulmonary resuscitation (DNACPR) documentation. This was an issue that was highlighted at the 2016 inspection
- There were inconsistencies in recording end of life care training and competencies, including syringe driver training.
- There was no named non-executive director with the responsibility for end of life care. This was highlight at the last inspection.
- The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community. The end of life care strategy referenced key national guidance and included defined local priorities, outcomes and measures of success. Staff were engaged in the development of the end of life care strategy and SPCT staff understood their role in delivering the strategy. However, the strategy was only approved in June 2017 and therefore was not embedded fully.
- The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. Staff recorded risks relating to end of life care on divisional risk registers. However, there were some risks that were identified by the SPCT that were not included in the divisional risk register, including the lack of syringe drivers in the trust.
- The trust engaged with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively. However, at the time of our inspection the results of the formal bereavement survey were not available. There was no local survey, to gather the views and experiences of bereaved relatives nor any patient representation in the end of life care and bereavement steering groups.

However:

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.

Summary of findings

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. The nurse staffing for the specialist palliative care team (SPCT) was in line with national guidance. This was an improvement since our last inspection.
- The service provided care and treatment based on national guidance and evidence of its effectiveness where the organisation did not meet clinical indicators there were actions from audits in place. The trust only audited preferred place of death or preferred place of care of patients that have been referred to the SPCT, so were unable to measure the efficacy of the service.
- The SPCT provided a seven-day service which was an improvement from the last inspection. The service was extended to seven days in September 2017.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Staff treated patients with compassion, dignity and respect.
- Staff involved patients and those close to them in decisions about their care and treatment. The service had open visiting hours, allowed relatives and carers to stay overnight and made arrangements to meet individual's needs.
- Staff provided emotional support to patients to minimise their distress. The trust gave patients and carers information on what to expect following the death of a loved one, and sign posted families to relevant information and support, including counselling services provided by external providers.
- The trust planned and provided services in a way that met the needs of local people. The trust had a system in place to highlight patients who were at the end of their lives by putting a blue border around their bed space on the electronic ward system for ease of identification and discussed at board round. However trust's audit process for preferred place of death or preferred place of care (PPD/PPC) was not robust as it only included those patients who have been referred to the specialist palliative care team.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. All complaints relating to end of life care were reviewed by the specialist palliative care team (SPCT) and discussed at the clinical governance meeting. Staff were aware of themes in complaints around end of life care and could identify areas of learning.

Outpatients

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings. We rated it as requires improvement because:

- Outpatient staff were not always trained to the appropriate level for safeguarding children and there was low compliance in some areas of mandatory training, such as resuscitation and the Mental Capacity Act.
- Records were not always stored securely and medicines were not always stored appropriately in outpatient areas.
- Not all equipment in dermatology and dialysis areas was maintained and fit for use.
- Incidents were not always reported and investigations not always completed in a timely manner. Only 2.8% of staff had received training on the use of the incident reporting system and staff responsible for carrying out incident investigations had not always received the training to do so.
- We could not be assured that compliance with the World Health Organisation (WHO) safety checklist would be monitored on an ongoing basis in ophthalmology and we were not provided with evidence that compliance with the WHO checklist had been audited in dermatology.
- Appraisal rates were below the trust target.

Summary of findings

- Audit action plans did not always have due dates or owners of actions and had not always been updated with outcomes.
- Data on waiting times was not formally recorded and therefore efficiency and areas for improvement could not be monitored and identified.
- Patients did not always have privacy when being weighed or when speaking to a receptionist
- People could not always access the service when they needed it. Waiting times from referral to treatment were not in line with the national England average in 10 specialities and backlogs had increased.
- Clinics continued to run behind time. We observed, and patients told us, that clinics frequently ran late, however the trust did not monitor clinic waiting times formally to enable oversight and improvement.
- An average of 325 clinics a month (19.3%) were cancelled at short notice (under six weeks).
- There was limited ongoing monitoring of quality assurance in the outpatient service. An outpatient dashboard had been discontinued in 2016
- There was no long term vision or strategy for the outpatient department as a whole and staff were not aware of the trust strategy.
- The service did not always effectively plan to eliminate risks; 44% of outpatient risks had been on the risk register for over four years.
- There was not always a documented review of actions from previous meetings or a discussion of areas for escalation during specialty governance meetings. Governance meetings were held on a quarterly basis in ophthalmology and this may have led to a delay in escalating issues to a divisional level.
- The service was not always managing information effectively. Staffing related information held by the trust, such as training, appraisals and vacancy numbers, did not always clearly show outpatient staff, there was no effective monitoring system to ensure incidents were closed in a timely manner and audit action plans were not always robust.

However:

- There had been improvements in staff understanding of the incident process and the sharing of learning.
- There had been improvements in the condition of notes and quality of documentation in patient records.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean.
- There were effective processes in place to monitor waiting lists and performance against waiting time standards.
- There was an appropriate process for responding to risk in patients that were waiting for appointments.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- The service had systems in place to ensure compliance with relevant best practice and national guidance. The service took part in relevant accreditation schemes.
- Staff understood their roles and responsibilities under the Mental Capacity Act 2005. They knew how to support patients who lacked the capacity to make decisions about their care.
- Staff cared for patients with compassion, involved them in decisions about their care and treatment and provided them with emotional support to minimise their distress.

Summary of findings

- Outpatient specialties offered some out-of-hours appointments, one-stop clinics, community based appointments, and telephone appointments, which provided patients with flexibility and choice.
- The service took account of patients' individual needs. For example, the trust had two full time learning disability liaison nurses, who could identify reasonable adjustments for patients in coordination with outpatient areas.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.
- Managers had the right skills and abilities to run a service providing high-quality sustainable care. Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service engaged well with patients and staff to plan and manage appropriate services.

Diagnostic Imaging

We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings. We rated it as requires improvement because:

- Diagnostic imaging staff were not always trained to the appropriate level for safeguarding children and there was low compliance in some areas of mandatory training.
- Equipment was ageing and there was no capital replacement programme in place. Specialised personal protective equipment was not always being checked on a regular basis. Resuscitation trolleys were not always being checked on a regular basis.
- Security and access to controlled areas was not consistent.
- Contrast media was not stored appropriately, in a temperature monitored and secure area, within the diagnostic imaging service areas.
- The emergency call bell system within nuclear medicine had not been fit for purpose since 2015.
- The diagnostic imaging service was not always meeting NHS England *Seven Day Services Clinical Standards*.
- Recommended changes to practice as a result of audit findings did not always identify the individual responsible for implementing changes or the date by which the change should have been implemented.
- Written consent for radiological procedures was not consistently undertaken in line with the trust's standard operating procedure.
- The diagnostic imaging environment did not always afford patients with privacy and dignity.
- Friends and Family Test scores were below the national average, and there were low response rates.
- Reporting times were not meeting targets in the majority of diagnostic imaging areas.
- Managers had not identified or put in place actions to address a number of the concerns that were identified during our inspection and action had not been taken to address some of the concerns identified at our previous inspection. Risks were not always resolved or acted upon in a timely manner and the risk register did not reflect all of the risks identified during this inspection.

However:

- There had been improvements in staff understanding of the incident process and training provided for those undertaking incident investigation and root cause analysis..

Summary of findings

- Progress had been made in the recruitment of new staff to address previously high vacancy levels.
- Appraisal rates were in line with trust targets and the service offered staff the opportunity for development and progression in their roles.
- The service was regularly reviewing the effectiveness of care and treatment through a comprehensive range of audits.
- Staff cared for patients with compassion, involved patients in decisions and provided emotional support to minimise distress. Feedback from patients confirmed that staff treated them well and with kindness.
- The service took account of patients' individual needs and offered out of hours, walk-in and one stop services to provide flexibility and choice. The service gathered the views of patients to ensure that services were being provided in a way that met their needs.
- Staff said that they felt proud to work in the organisation and described supportive relationships with colleagues. Staff said that their managers were approachable and supportive. None of the staff spoken to on this inspection raised concerns about bullying or harassment.

Urgent and emergency services

Inadequate ● ↓↓

Key facts and figures

The urgent and emergency service at the Norfolk and Norwich University Hospital consisted of an emergency department (ED), which was a type one major injuries unit with a reception and waiting area, 18 'majors' assessment cubicles, an area that could accommodate three trolleys for patients awaiting ward transfer, and a six-bedded resus area including a paediatric and cardiac bay.

There was a separate children's ED which consisted of four assessment areas and a separate waiting area, and a 12-bedded clinical decision unit which was located within the hospital's Acute Medical Unit (AMU). The urgent and emergency service operated 24 hours a day, seven days per week. Patients could access the urgent and emergency service either by walking in via the ED reception or arriving by road or air ambulance.

For people attending the ED presenting as less urgent or with minor injuries they were assessed in ED and streamed to the urgent care centre (UCC). The UCC was located in the same building as the ED but accessed through a separate entrance. The centre provided an ED minors unit which had six assessment areas and a GP service. The minors unit was open seven days a week 08:00am to 02:00pm and the UCC also seven days a week from 08:00am to 11:00pm.

The ED department was originally built for a predicted 82,000 attendances, however, between April 2016 and March 2017 there were 127,956 attendances at Norfolk and Norwich University Hospitals NHS Foundation Trust. The trust has recently opened the Older Persons Emergency Department which created potential space for an additional 38,000 people. Approximately 20% of these attendances were children (those under the age of 18 years). The percentage of A&E attendances at this trust that resulted in an admission fell between 2015/16 and 2016/17. In 2016/17, rates were higher (24.3%) than the England average (21.6%). The trust serves North Norfolk which has one of the oldest populations in the UK.

The urgent and emergency division within the trust also consisted of the AMU. We did not inspect this area in line with our inspection methodology; however, the data we have reported on does at times incorporate data from this area because this is how the trust reports its data.

We last inspected the urgent and emergency service in November 2015 where overall we rated it as "good", with safety as "requires improvement". Safety required improvement because the children's ED was not fit for purpose in terms of size, the main ED was overcrowded and the capacity did not meet demand, doctors were not compliant with bare below the elbow infection control requirements, there was a shortage of registered children's nurses and there was a poor rapport between medical and nursing teams.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. During this inspection we visited the ED, children's ED, CDU and the UCC. We spoke with 54 members of staff including doctors, nurses, support workers, administrative staff, cleaners, advanced clinical practitioners and senior managers. We reviewed the healthcare records of 23 people who used the service, observed care; we also spoke with 12 people who used the service, and three relatives and carers. Before and after our inspection we analysed extensive service data the trust provided.

Summary of this service

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

A summary of our findings about this service appears in the Overall summary.

Urgent and emergency services

Is the service safe?

Inadequate ● ↓

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

- The service did not use safety monitoring results well in order to improve services. There was a delay in action taken as a result of serious incident investigation. This included a serious incident involving multiple restraints of a patient where lessons learnt were not embedded into practice.
- Action plans for Root Cause Analysis (RCA) investigations were not monitored or kept up-to-date. Managers we spoke with but who undertook RCA did not have training in undertaking an RCA. Senior managers had not received training on the Duty of Candour despite being involved in these conversations
- There were no mortality and morbidity meetings for the service. Whilst mortality and morbidity was a standing agenda within the monthly clinical governance meetings, the incomplete meeting minutes meant we could not be assured mortality and morbidity was reviewed regularly nor fed in to service improvement.
- Infection, prevention and hygiene had deteriorated since our last inspection. Records were not kept to show the cleaning carried out by housekeeping staff or what cleaning they were required to do. "I am clean stickers" were not consistently used and there was a lack of hand washing facilities throughout the service. Staff did not follow the trust policy in relation to isolation procedures and there was no sluice in the children's emergency department (ED).
- Mandatory training compliance was significantly below the trust's target. For example, only 54% of medical staff had completed their mandatory training. Staff training on infection, control and prevention was poor. For example, only 61.9% of medical staff had completed their level three training. Training on sepsis was not mandatory and there was no formal sepsis training session available to staff.
- Emergency equipment was not available at all times, stored safely nor properly maintained. There were no ligature cutters, children's resuscitation equipment was locked, uncased oxygen cylinders were stored on the floor and there were no checking systems in place for the oxygen and suction in the observation room in the main ED.
- The Rapid Assessment and Treatment (RAT) system was not an embedded process nor used regularly. Staff told us that this process was used less frequently due to capacity and consultant staffing restraints. When the RAT system is used it is effective as the consultant is able to assess the patient and make rapid decisions regarding care, order tests and redirect patients as appropriate. During inspection the team regularly checked the RAT column on the department's electronic ED system and saw that RAT was not being used frequently.
- An escalation and trigger tool for the service was not available to staff as it was under review at the time of our inspection.
- At times of peak pressure, patients were being cohorted in the emergency department corridor and substantial waits, at times over seven hours; to offload from ambulances were compromising patient care. Due to the demand medical and nursing staff were not able to ensure that patients waiting in the corridor were seen and treated in a timely manner. We spoke to three staff who told us that delay in assessing and treating patients waiting in the corridor had impacted on their health. In February only 56% of patients were seen and treated within four hours of arrival at the majors department. Nationally 77% of patients were treated within this timeframe. The hospital had not met this target since August 2016.
- Actual medical and nursing staffing numbers were significantly lower than planned and vacancy rates for medical staff were high (27.5%). There was no medical lead in post at time of inspection.

Urgent and emergency services

- The planned number of registered children's nurses were not always on duty at all times and most shifts where this was achieved, only one of two registered children's nursing shifts were filled. We had raised this concern previously at our last inspection in November 2015; therefore, the trust had not taken necessary action to improve this concern nor in a timely way. In addition, there was not always a good skill mix of nurses working in the children's ED.
- There were significant gaps identified in the healthcare records of mental health patients. For example, necessary risk assessments including environmental, dementia assessments and deliberate self-harm proformas were missing or incomplete. Mental capacity assessments were not carried out where required. Staff displayed limited understanding of caring for patients within diminished capacity and we found restraint practices were used instead of de-escalation techniques, which meant a safety risk to patients.
- In November 2015 we had concerns about the environment within the main ED and the paediatric ED. The trust had initiated a building programme to mitigate these risks in the longer term but had not taken effective immediate action to mitigate the risks on a day-to-day basis. When we returned in March 2018 the re-located and expanded paediatric ED and the older persons ED were open. However separate staffing was only provided between 9am and 5pm. Outside of these times it was staffed by ED staff.
- Multiple areas throughout the service were not being used as intended. This included the corridor, observation bay and review clinic which were used daily as an extension of the majors department. The quiet room was being utilised as a secure place for patients with mental health issues. However, this had not been risk assessed nor equipped appropriately. The trust took immediate action to ensure the safety of patients and staff following our inspection. At our inspection in March 2018 we saw that work had commenced to build a designated mental health suite. Although improvements had been made to the quiet room we saw a patient being treated there with the door open to the corridor where other patients were waiting to be seen.
- In October 2017 we found that there were no security restrictions in place when entering the children's ED. This had meant that any person in majors could access this area and children could abscond. This had not been risk assessed. The trust responded immediately to our concerns. By the follow up inspection on 23 October 2017 a risk assessment had been carried out and necessary action had been taken to secure the area. In March 2018 the new department was opened and had secure access.

However:

- Staff understood their responsibilities to raise concern, to record safety incidents, concerns and near misses, and they reported these appropriately. People who used the service were told when they were affected by something that went wrong, given an apology and informed of any actions taken.
- Safeguarding systems, processes and practices for both children and adults were robust and effective.
- The arrangements for managing medicines (with exception to medical gases) was safe. We also found that the service had taken appropriate action following our last inspection in November 2017 to ensure triage nurses were competent to administer medication via patient group directives (PGD).
- There was a clear streaming process in place. Patients arriving at the entrance of the main ED reception were assessed by a senior nurse and directed to the most appropriate department such as childrens ED, majors or the urgent care centre.
- There were robust clinical pathways in place for patients, which we saw operate effectively, and sepsis screening tools and bundles were in use.

Urgent and emergency services

Is the service effective?

Requires improvement   

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

- Staff throughout the service were not able to demonstrate sufficient understanding of the Mental Capacity Act (2005), Mental Health Act (1983) and DoLS. There were low numbers of staff trained in either of these pieces of legislation or how to apply them.
- There was no annual audit programme in place which meant a lack of oversight of local audit undertaken. Local audits were not always used to drive improvements. For example, there was a lack of action plans for some and no recordings of actions taken for other audits. This applied to both local and national audit results. This was a significant change to our findings in our inspection in November 2015 where the service could demonstrate learning from audits was used to improve the services provided.
- The service did not monitor compliance with the Mental Health Act (MHA) Code of Practice, despite it being trust policy for this to be audited six monthly.
- Records showed that only 36% of nursing, 26.7% of healthcare support workers and 36% of administrative staff had received an appraisal in the past year.
- Prevention and Management of Aggression (PMA) training was part of mandatory training. However only 14.8% of medical staff, 57.4% of nursing and 54.5% of healthcare support workers had completed this training. Members of staff were not always aware of de-escalation techniques.
- We had concerns about how the security company employed by the trust managed restraint within the ED. We were told by senior managers that this issue was being addressed.

However:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. This included the pathway for fractured neck of femur and acute stroke. These pathways were seamless and impressive.
- Patients had their nutritional and hydration needs assessed and met.
- Pain management was effective.
- Patient outcomes for people using the service were generally good. This is in relation to Royal College of Emergency Medicine audit results and CQUIN data on sepsis.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- There were a number of seven-day services available included radiology, the mental health liaison team and pharmacy.

Is the service caring?

Good  

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

Urgent and emergency services

- We observed other staff take time to interact with patients, act in a caring manner and be exceptionally kind to patients and those close to them.
- In March 2018 we saw that staff in the emergency department were passionate about providing patients with the best possible care and were visibly upset and frustrated when this could not be achieved.
- Results from the Friends and Family Tests for the service were consistently good.
- Patients told us that they understood and felt involved in their care and treatment decisions.
- There was a range of emotional support available to patients and staff, including the chaplaincy service, staff counselling and children's nursery nurses were employed to provide emotional support to children.

However:

- During our October inspection we observed two episodes of care whereby staff attended to patients in an uncaring way. We saw that staff provided care without explaining this to the patient in anyway.
- We observed security guards throughout the service acting in an uncaring manner towards patients. For example, we witnessed an incident whereby two security guards who were attending to one patient in the major's area spoke in a remarkably disrespectful way about the patient, in front of the patient to a cleaner. The trust took action to address this as soon as we raised this with them.

Is the service responsive?

Requires improvement ● ↓

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

- People could not always access the service when they needed it. Waiting times from treatment and arrangements to admit treat and discharge patients were not in line with the England average.
- 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 A&E. The trust had failed to meet the standard since 30 September. In February 2018 only 56% of patients were treated within four hours. This was not in line with the national average for February 2018 which was 77%.
- Between September 2016 and August 2017, Norfolk and Norwich University Hospitals NHS Foundation Trust's monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted was worse than the England average, although there was a trend of improvement in June and July 2017.
- In March 2018 we found that patients were waiting in the corridor at times of exceptional demand for many hours. We saw that there was a mobile screen used to maintain privacy and dignity whilst undertaking examinations or bodily functions however we also saw staff undertaking clinical histories from patients in the corridor without using these. This did not maintain the patient privacy or dignity.
- Senior managers were unable to demonstrate that lessons were learnt from concerns and complaints, nor show that action was taken as a result to improve the quality of care.

However:

- The trust planned and provided services in a way that met the needs of local people. They developed innovative ways to ensure the service was as responsive as possible given the demands on the service.
- The service took account of patients' individual needs.

Urgent and emergency services

Is the service well-led?

Inadequate ● ↓↓

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

- We identified a number of issues that were a risk to patient safety, which had not been identified or addressed by the leadership team until we raised them during our inspection. For example, there were no security restrictions in place when entering the children's ED and this had not been risk assessed. However, the senior leadership team did take action to address concerns once they had been raised by the inspection team.
- In addition, the leadership team had failed to address a number of concerns that were highlighted during our previous inspection in 2015. For example, in November 2015 we had concerns about the environment within the main ED and the paediatric ED. There had been no changes to the environment in main ED and paediatric ED by the time of our inspection in October 2017, although the trust had initiated a building programme in the longer term.
- Effective systems were not in place to ensure patient safety improvements were made following incidents, complaints and audits. For example, implementation of learning from incidents was not always robust. The action plans for serious incidents were not kept up-to-date therefore we could not be assured that appropriate action had been taken following lessons learnt identified. For example, lessons learnt from a serious incident involving multiple restrains of a patient were not embedded into practice.
- There was a lack of grip and oversight over access and flow in the emergency department. For example, rapid assessment and treatment did not occur, at time of peak pressure patients waited in corridors, clinical staff stated they could not adequately assess these patients, patients waited long periods of time for specialist review and we saw evidence where delays had negatively impacted on patient care.
- We found that nursing and medical staff raised concerns over patient safety and responsiveness to managers but that these were not addressed. Some staff had formally written to the trust about these concerns but had not received a satisfactory response at the time of our inspection in March 2018. Staff did not feel supported by the senior team, above the level of matron, and felt that when they raised concerns this was met with a "just do it" response.
- Whilst the trust has undertaken plans to integrate the ED with the rest of the hospital, in March 2018 staff told us that they felt that there was a lack of cohesive working with the ED from other departments, or what actions the senior team were taking to address this. We saw waits for consultations of over seven hours. Staff told us that this was not unusual and that they felt that the rest of the hospital did not appreciate the issues in the ED.

However:

- Staff including senior managers had a clear vision and strategy in place for what they wanted the service to be, with quality and safety as a top priority.
- Managers for the service had taken appropriate action in relation to the concerns we raised in November 2015 about poor attitude between nursing and medical staff. Staff across all levels told us that the medical and nursing team within the department worked collaboratively and shared responsibility to deliver good quality care. We observed this consistently.
- Leaders were approachable, visible and encouraged appreciative, supportive relationships among staff. There was a strong culture of candour, openness and honesty throughout the service.

Urgent and emergency services

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

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

Surgery

Inadequate ● ↓

Key facts and figures

Norfolk and Norwich University Hospital NHS Foundation Trust (NNUH) provides a full range of general and tertiary surgical services across two sites, Norfolk and Norwich University Hospital and Cromer Hospital. The services covered included: General Surgery, Urology, Trauma and Orthopaedics, Ear, Nose and Throat, Ophthalmology, Oral Surgery, Plastic Surgery, Thoracic Surgery, Vascular Surgery, Pain Management and Interventional Radiology. Many specialties run a hub and spoke services meaning that minor surgeries are carried out at other services in the area, with complex surgery performed at Norfolk and Norwich University Hospital.

Between April 2016 and March 2017 there were 15,867 emergency admissions and 8,916 were elective. There were also 23,461 day admissions during the same time period.

The service had 312 beds that were situated across six surgical wards

The trust has 28 theatres; six in the Day Procedure Unit, 17 in the main theatre complex, two obstetrics, two ophthalmic and one theatre at the Cromer site. Elective surgery was provided Monday to Saturday. There were three emergency theatres to accommodate emergency operating at all times.

The Interventional radiology unit (IRU) lists run Monday to Friday 8am to 6pm, with a 24 hour and weekend on call service. IRU has a five-bay recovery area, with a suite located in the Cath labs on Mondays and Fridays.

There were established pathways in place for both elective and emergency surgical admissions.

Within surgical services there were 1,215 whole time equivalent medical/nursing staff.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. The inspection was undertaken at the Norfolk and Norwich hospital, we did not include Cromer hospital as part of this inspection.

During this inspection we visited five wards, the day procedures unit and main theatres. We spoke with 53 members of staff, which included surgical and nursing staff, pharmacists, allied health professionals, operations staff and the divisional lead nurse. We spoke with 13 patients and two patient's relatives and reviewed 23 sets of patient records

Summary of this service

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

A summary of our findings about this service appears in the Overall summary.

Is the service safe?

Inadequate ● ↓

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

- We found that there was a failure to implement learning from serious incidents and never events, specifically within theatres and the interventional radiology unit (IRU). We reported during the April 2017 inspection that there had been four never events, since June 2017 there had been a further five never events reported in surgery.

Surgery

- Compliance with the World Health Organisation (WHO) and five steps to safer surgery checklist was inconsistent. There was a failure from staff to challenge poor practice and ensure the safety checks were completed appropriately.
- The induction and recovery area for the interventional radiology unit was in a corridor that was a busy thoroughfare. This area had not been risk assessed. We identified a range of concerns in relation to the environment, equipment and medicines management in this area. Several items of equipment were found to be significantly out of date. There were no regular checks of the emergency and intubation equipment in this area. We raised this on site and the trust took action to address these concerns.
- We identified significant issues with infection prevention and control within the day procedure unit (DPU), IRU and theatres. This included staff failure to follow basic infection prevention procedures and a failure to identify and cohort infected patients appropriately in both IRU and DPU.
- There were inconsistent process and procedure to ensure resuscitation and emergency equipment was available and ready to use. Resuscitation trolleys were not tamper proof. In theatres we found gaps in the daily check sheets for resuscitation trolleys, fridges and ambient room temperature where medication was stored. Records of blood fridge temperatures were missing and therefore the trust could not be assured of the efficacy of the blood products stored within these fridges.
- The day procedure unit was being utilised as an escalation area. Staff had raised concerns relating to the unsuitability of the environment and lack of appropriate competence to care for the multispecialty patients that were admitted. These included patients with complex medical conditions, patients at the end of life and patients living with dementia.
- There was an increased risk to patient safety in DPU due to lack of equipment, medication omissions and difficulty in getting timely medical review. Patients were at risk of developing pressure sores and increased falls. In patient quality round for escalation areas had been introduced but were not consistently completed.
- We received several whistle blowers highlighting staff concern for patient safety following the reconfiguration of Edgefield ward to combine urology and vascular specialties. We found a lack of evidence of formal staff training, staffing levels were not always in line with planned levels and we found gaps in monitoring of catheters, intentional rounding and completion of National Early Warning Score observations

However:

- Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The surgical wards prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.

Is the service effective?

Good   

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

Surgery

At the focussed inspection of April 2017 effective was not inspected and therefore not rated. During our comprehensive inspection in November 2015 we gave the service a rating of good for effective. Therefore, the rating of effective stayed the same. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.
- The service monitored the effectiveness of care and treatment.
- The service made sure staff were competent for their roles. Managers held supervision meetings with staff to provide support and monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care, despite training compliance being 60%.

However:

- Appraisal rates were below trust target and ranged between 40% and 77% dependent on staff group. The only group meeting the target of 80% were the health care scientist staff group (96%).
- Compliance with written consent for interventional radiological procedures was particularly poor in certain modalities which increased the risk to patient safety. The modalities with the lowest compliance were fluoroscopic lumbar punctures at 0 % and ultrasound guided liver biopsies and trunk drainages at 10 %.

Is the service caring?

Good   

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

At the focussed inspection of April 2017 Caring was not inspected and therefore not rated. During our comprehensive inspection in November 2015 we gave the service a rating of good for Caring. Therefore the rating of Caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff provided emotional support to patients to minimise their distress.
- The staff on the day procedure unit were passionate about providing patients with the best possible care and were visibly upset and frustrated when this could not be achieved.

However:

Surgery

- The induction and recovery area for the interventional radiology unit did not afford patients with privacy and dignity. We raised concerns about this area during our inspection and the trust took immediate action to respond. An action plan was implemented with a completion date of November 2017.

Is the service responsive?

Requires improvement ● → ←

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

- People could not always access the service when they needed it. The trust's referral to treatment time for admitted surgical pathways was consistently worse than the England average, although there was an improving picture between April and June 2017.
- The percentage of cancelled operations at the trust was consistently worse than the England average. The trust has at times hit in excess of 25% which is very high against an England average of around 6%. Although we did observe that there was an improving picture in 2017 from previous years.
- The facilities and premises for the interventional radiology unit were insufficient to meet demand. Previous business cases had failed to progress due to physical and financial restrictions. Current revised plans were in place however extended facilities would not be completed until 2019.
- The trust did not investigate and close complaints in the timescales set by their own policy.

However:

- The service took account of patients' individual needs.
- The service worked together with local CCG's to create new surgical pathways.
- The length of stay for the majority of specialities was in line or lower (better than) the England average for both elective and emergency patients. The exception to this was general surgery which was slightly higher in comparison for elective patients.
- The service investigated complaints and identified lessons that could be learnt which were shared with all staff.

Is the service well-led?

Inadequate ● ↓

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

- We identified a number of significant issues that impacted on patient safety, such as the concerns in interventional radiology and infection control processes that the leadership team had failed to recognise.
- Actions taken by the leadership team had not been effective to address issues identified at our previous inspection in April 2017; these included the culture and governance within main theatres, compliance with staff mandatory and safeguarding training targets and review of the integrity of personal protective equipment within IRU.
- Processes and regular observational audit had not been embedded to ensure that the World Health Organisation (WHO) and five steps to safer surgery checklist was appropriately undertaken

Surgery

- There was a failure to learn from incidents and never events and a lack of response from leaders to tackle patient safety concerns that were raised by staff, specifically within main theatres, interventional radiology unit, day procedure unit and Edgefield ward.
- There was a lack of accountability by both nursing and medical members of the team to recognise and challenge poor practice. Poor practice had become normalised and we found examples of this in main theatres and IRU.
- The level of risk management and oversight in the theatre department and the level of support from the divisional triumvirate was a significant ongoing issue. New theatre governance processes that we were informed about on our April 2017 inspection had yet to be implemented and processes in place to replace equipment were not timely.
- Safety and quality assurance processes in theatre continued to be lacking with infection prevention processes, resuscitation equipment checks and monitoring of blood and medication fridge temperatures being inconsistent.
- We were not assured that staff felt comfortable raising patient safety concerns internally or that they would be supported should they do so. When we inspected on the 22 March 2018, staff told us that they were raising concerns internally but felt no one senior was listening. Eleven out of nineteen whistle-blowers, between January and March 2018, referred to staff being pressured on the wards to accept additional patients, that they often felt were unsuitable for the ward due to the acuity of care needed. Five whistle-blowers related specifically to the day procedure unit and two related to Edgefield ward.

However:

- The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- Staff across the service spoke highly of their ward managers and the support they offered.
- The trust collected, analysed, managed and used information well to support all its activities.

Areas for improvement

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

End of life care

Requires improvement   

Key facts and figures

Norfolk and Norwich University Hospital provides palliative and end of life care to patients across all its clinical areas and treats a variety of conditions. The hospital does not have a dedicated palliative and end of life care ward. There were 2412 in-hospital deaths in the year from June 2016 to May 2017.

The specialist palliative care team (SPCT) consists of palliative care consultants, specialist palliative care nurses, end of life care educators, and administrative staff. The SPCT provide advice, assessment and treatment to patients across all clinical areas within the hospital. They also support ward staff to deliver care to patients at the end of their life. The team are available Monday to Saturday between the hours of 9am and 5pm. On Sunday the team is available between 8am and 1pm. Out of hours advice is provided via switchboard to contact the on call palliative medicine consultant to provide advice and support.

The specialist palliative care team is comprised of 6.9 whole time equivalent (WTE) clinical nurse specialists, including the lead nurse for palliative care. Five palliative care consultants, who together make up 4 WTE, and 2.8 WTE administrative staff. End of life care in the trust is also supported by 1 WTE end of life care educators.

Palliative and end of life care champions were identified within each clinical area and team, including allied health professionals. Champions were given additional ongoing training to support them within their roles. This is undertaken by the end of life care educators.

During this inspection we visited 13 wards and units at Norfolk and Norwich University Hospital, including older people's medicine wards, Stroke wards, the Accident & Emergency, hospital mortuary, and the hospital chapel. We spoke to 46 members of staff, which included medical and nursing staff, allied health professionals, the SPCT, the director of nursing, discharge coordinators, mortuary and chaplaincy staff. We spoke to two patients who were at the end of their life and three patients' relatives. Care records for 12 patients receiving end of life care, 35 do not attempt cardiopulmonary resuscitation (DNACPR) records and seven prescription charts were reviewed during the inspection

Summary of this service

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

A summary of our findings about this service appears in the Overall summary.

Is the service safe?

Requires improvement   

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

- There was a significant lack of syringe drivers in the trust. This was an issue identified at the 2015 inspection. Only 55% of patients had a syringe driver in place within 24 hours or patient needing regular anticipatory medications. The trust had not taken steps to address the shortfall in a timely manner. We were informed that there were plans to purchase an additional 40 syringe drivers.

End of life care

- During this inspection staff told us that they reported shortages of syringe drivers as incidents. There had been three incidents reported that related to delay in controlling patients pain due to a shortage of syringe drivers. Clinical governance minutes from September 2017 also stated the fact that the lack of syringe drivers was impacting on patient care and had reached a critical stage.
- There were inconsistencies in recording the syringe driver training and competencies across the trust. This meant the trust could not be assured that training was provided to appropriate staff, in a timely manner.
- There were some inconsistencies in adhering to the four hourly syringe driver checks, as per trust policy. In two out of the four checklists for syringe drivers we reviewed, four hourly checks were not consistently carried out. In one record there was seven hours between checks.

However

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. The staffing for the specialist palliative care team (SPCT) was in line with national guidance and were up to date with mandatory and safeguarding training. This was an improvement from the last inspection.
- Staff completed individualised care plans for patients receiving end of life care. This was in line with national guidance and was an improvement since our last inspection.
- The service planned for emergencies and staff understood their roles if one should happen.

Is the service effective?

Requires improvement ● → ←

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

- The trust's 'do not attempt cardio-pulmonary resuscitation' forms did not meet national standards and were not always completed in line with national standards or the trusts own policy.
- We were not assured that the Mental Capacity Act and Deprivation of Liberty Safeguards were always implemented for people who had do not attempt cardio pulmonary resuscitation (DNACPR) documentation. This was an issue that was highlighted at the 2016 inspection.
- There were inconsistencies in recording end of life care training and competencies, including syringe driver training.
- Following the March 2016 National Care of the Dying Audit the service was an outlier for two out of the five clinical outcomes. An action plan had been devised with both outcomes addressed as part of the individualised care plan (ICP). At time of inspection the ICP was being piloted in two wards, and was yet to be rolled out across the trust. The planned audit for the ICP was March 2018 this meant that the trust had no data to evidence improvement since the March 2016 national audit.

However:

End of life care

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Where the organisation did not meet clinical indicators, there were actions from audits in place. The trust only audited preferred place of death or preferred place of care of patients that have been referred to the SPCT, so were unable to measure the efficacy of the service.
- The SPCT provided a seven-day service which was an improvement from the last inspection. The service was extended to seven day in September 2017.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment.

Is the service caring?

Good ● → ←

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

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Staff treated patients with compassion, dignity and respect.
- Staff involved patients and those close to them in decisions about their care and treatment. The service had open visiting hours, allowed relatives and carers to stay overnight and made arrangements to meet individual's needs.
- Staff provided emotional support to patients to minimise their distress. The trust gave patients and carers information on what to expect following the death of a loved one, and signposted families to relevant information and support, including counselling services provided by external providers.

Is the service responsive?

Requires improvement ● → ←

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

- Whilst the trust had improved the monitoring of patient preferred place of care (PPC) and preferred place of death (PPD) this required embedding and improving.
- The trust target for achieving PPC / PPD was low at 29%. Data provided showed that, between April and September 2017, on average 31% of patients referred to the specialist palliative care team achieved their first or second choice of PPC/PPD. This had declined since our last inspection.
- There was no formal monitoring of the timeliness of fast track discharge although staff told us there were no delays in discharge this was not recorded. Without a formal mechanism to audit and monitor fast track the trust could not identify issues or themes that may be impacting on this to enable actions to be identified and evidence service improvement.

However:

- The service took account of patients' individual needs. Staff took account of the spiritual and religious needs of patients.
- The trust planned and provided services in a way that met the needs of local people. The trust had a system in place to highlight patients who were at the end of their lives by putting a blue border around their bed space on the electronic ward system for ease of identification and discussed at board round.

End of life care

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. All complaints relating to end of life care were reviewed by the specialist palliative care team (SPCT) and discussed at the clinical governance meeting. Staff were aware of themes in complaints around end of life care and could identify areas of learning.

Is the service well-led?

Requires improvement ● → ←

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

- There was no named non-executive director with the responsibility for end of life care. This was highlight at the last inspection in 2015.
- The end of life care strategy was only approved in June 2017 and therefore had not been embedded fully.
- At the time of the inspection, results of the formal bereavement survey were not available. There was no local survey, to gather the views and experiences of bereaved relatives nor was there any patient representation in the end of life care and bereavement steering groups.

However:

- The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. The director of nursing was the executive lead for end of life care.
- The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community. The end of life care strategy referenced key national guidance and included defined local priorities, outcomes and measures of success. Staff were engaged in the development of the end of life care strategy and SPCT staff understood their role in delivering the strategy.

Areas for improvement

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

Outpatients

Requires improvement ●

Key facts and figures

Norfolk and Norwich University NHS Foundation Trust provides outpatient services from two locations, Norfolk and Norwich Hospital and Cromer Hospital. We did not inspect Cromer Hospital during this inspection.

Between June 2016 and May 2017 there were 768,341 outpatient attendances at the trust.

Outpatient services are provided for a wide range of specialties including anti-coagulant/venous thromboembolism (VTE), audiology, cardiology, gastroenterology, respiratory, rheumatology, paediatrics, ophthalmology, physiotherapy, general surgery, ear, nose and throat (ENT), oncology, dermatology, diabetes, trauma and orthopaedics, neurology, general medicine, and urology.

Outpatient services are managed within all four of the hospital's divisions, dependent on their specialty.

Outpatient appointments are available Monday to Friday, with occasional evening and weekend clinics dependent on speciality, capacity and need.

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

The last inspection in October 2015 reported concerns regarding incident reporting and correct identification of harm and the trust was failing to meet some of its treatment time targets.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust. During the inspection visit, the inspection team spoke to 26 members of staff, including nursing staff, health care assistants, doctors, housekeeping staff, administrative staff, and managers. We spoke to 14 patients and relatives, reviewed 12 patient records and observed four consultations.

Summary of this service

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings. We rated it as requires improvement

A summary of our findings about this service appears in the Overall summary.

Is the service safe?

Requires improvement ●

We rated safe as requires improvement because:

- Incidents were not always reported and investigations not always completed in a timely manner. Only 2.8% of staff had received training on the use of the incident reporting system and staff responsible for carrying out incident investigations had not always received the training to do so. However there had been improvements in staff understanding of the incident process and the sharing of learning.
- There was low compliance in some areas of mandatory training, such as resuscitation and the Mental Capacity Act.

Outpatients

- Outpatient staff were not always trained to the appropriate level for safeguarding children.
- Security of records was not consistent in all outpatient areas.
- Medicines were not always stored appropriately in outpatient areas.
- Not all equipment in dermatology and dialysis areas was maintained and fit for use.
- We could not be assured that compliance with the World Health Organisation (WHO) safety checklist would be monitored on an ongoing basis in ophthalmology and we were not provided with evidence that compliance with the WHO checklist had been audited in dermatology.

However:

- There had been improvements in the condition of notes and quality of documentation in patient records.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean.
- There was an appropriate process for responding to risk in patients that were waiting for appointments.

Is the service effective?

We do not currently rate the effectiveness of outpatient services. However, we found the following areas of good practice:

- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- The service had systems in place to ensure compliance with relevant best practice and national guidance.
- Staff understood their roles and responsibilities under the Mental Capacity Act 2005. They knew how to support patients who lacked the capacity to make decisions about their care.
- The audiology department had achieved Improving Quality in Physiological Services (IQIPS) accreditation and sub-specialties within pathology had been accredited to Clinical Pathology Association (CPA) standards.
- The cardiology outpatients department had set up a physiotherapy cardiology breathing pattern disorder clinic in response to an identified patient need and had produced significantly improved patient outcomes.

However:

- Appraisal rates were below the trust target, and no formal clinical supervision was in place.
- Audit action plans did not always have due dates or owners of actions and had not always been updated with outcomes.
- Data on waiting times was not formally recorded and therefore efficiency and areas for improvement could not be monitored and identified.

Is the service caring?

Good 

We rated caring as good because:

Outpatients

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

However:

- Patients did not always have privacy when being weighed or when speaking to a receptionist.

Is the service responsive?

Requires improvement ●

We rated it as requires improvement because:

- People could not always access the service when they needed it. Waiting times from referral to treatment were not in line with the national England average in 10 specialities and backlogs had increased.
- Clinics continued to run behind time. We observed, and patients told us, that clinics frequently ran late, however the trust did not monitor clinic waiting times formally to enable oversight and improvement.
- An average of 325 clinics a month (19.3%) were cancelled at short notice (under six weeks). The most common reason for clinic cancellation was staff being on annual leave (37.8%).
- Some outpatient areas had space limitations which could impact on wheelchair users and, in some cases, this meant that patients had to wait for appointments in a corridor.

However:

- Outpatient specialties offered some out-of-hours appointments, one-stop clinics, community based appointments, and telephone appointments, which provided patients with flexibility and choice.
- The service took account of patients' individual needs. For example, the trust had two full time learning disability liaison nurses, who could identify reasonable adjustments for patients in coordination with outpatient areas.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Is the service well-led?

Requires improvement ●

We rated it as requires improvement because:

- There was limited ongoing monitoring of quality assurance in the outpatient service. An outpatient dashboard had been discontinued in 2016. Outpatients sat across the four clinical divisions which meant there was no overall lead for outpatient services. This resulted in disjointed leadership and inconsistencies in oversight across the various specialities.
- There was no long-term vision or strategy for the outpatient department as a whole.

Outpatients

- The service did not always effectively plan to eliminate risks; 44% of outpatient risks had been on the risk register for over four years.
- There was inconsistency with governance templates used across specialties and in some cases, this meant that there was no documented review of actions from previous meetings or discussion of any areas for escalation. Governance meetings were held on a quarterly basis in ophthalmology and this may have led to a delay in escalating issues to a divisional level.
- The service was not always managing information effectively. Staffing related information held by the trust, such as training, appraisals and vacancy numbers, did not always clearly show outpatient staff, there was no effective monitoring system to ensure incidents were closed in a timely manner and audit action plans were not always robust.
- Staff were not aware of the trust strategy and were not able to describe the trust values beyond the 'PRIDE' acronym.

However:

- Managers had the right skills and abilities to run a service providing high-quality sustainable care.
- There were effective processes in place to monitor waiting lists and performance against waiting time standards.
- Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

The service engaged well with patients and staff to plan and manage appropriate services.

Areas for improvement

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

Diagnostic imaging

Requires improvement ●

Key facts and figures

Norfolk and Norwich University Hospital (NNUH) NHS Foundation Trust provides diagnostic imaging services from two locations, Norfolk and Norwich Hospital and Cromer Hospital. We did not inspect Cromer Hospital during this inspection.

Radiology delivers approximately 500,000 examinations per annum across nine modalities.

Services offered within the radiology department include cardiac catheterisation laboratory (Cath lab), computerised tomography (CT), magnetic resonance imaging (MRI), ultrasound (general, antenatal and vascular scanning), plain film x-ray, fluoroscopic procedures, bone densitometry (DXA), and breast imaging & screening.

There are 340 members of staff working in diagnostic imaging services, including 30 radiologists.

Some CT, MRI and ultrasound activity is outsourced. MRI has the largest outsourced volume currently with 13.7% of the service going to external providers.

The plain-film imaging department consists of 13 x-ray rooms based over three clinical areas: main radiology, ED, and level three, which also offers a walk-in GP chest imaging service. Main radiology offers an extended weekday service and a two-session day at the weekends. The ED x-ray department is open 24 hours a day, seven days a week, 365 days per year and last year examined 82,226 patients. Out of normal hours the ED department provides plain film imaging for all in-patients, theatre imaging and mobile radiography.

Theatre imaging is provided across all theatres, the day procedure unit and the gastroenterology suite.

Fluoroscopy and CT (Virtual) Colonoscopy (CTC) provides an in-patient and outpatient service for adults, paediatrics and neonates.

CT provides diagnostic imaging and therapeutic services delivered 24 hours, seven days a week. CT provision comprises of a total of five scanners; four NHS, and one independent sector CT to undertake over 42,000 patient appointments each year.

There are two dedicated cardiac labs, with access to a third lab three days per week.

Diagnostic imaging services are managed within the clinical support services directorate.

We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings.

The last inspection in October 2015 reported concerns regarding incident reporting and correct identification of harm and the trust was failing to meet some of its treatment time targets.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection visit, the inspection team spoke to 38 members of staff, including radiographers, radiologists, cardiologists, radiology and cardiology assistants, administrative staff, and managers. The team also spoke to seven patients and relatives.

Diagnostic imaging

Summary of this service

A summary of our findings about this service appears in the overall summary.

We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings.

Our overall rating of this service was requires improvement

Is the service safe?

Requires improvement

We rated safe as requires improvement because:

- No diagnostic imaging staff had been trained to safeguarding children level three. This was despite 26,232 patients under the age of 18 being seen in diagnostic imaging areas between 1 October 2016 and 30 September 2017.
- Security and access to controlled areas was not consistent. There had been two incidents relating to key security in September 2017. Investigations were ongoing at the time of inspection and it was not yet clear what changes to practice would be implemented.
- Contrast media was not stored appropriately, in a temperature monitored and secure area, within the diagnostic imaging service areas.
- Resuscitation trolleys were not always checked on a regular basis.
- Equipment was ageing and there was no capital replacement programme in place.
- There was no effective process to annually check the integrity of lead aprons in use across all areas. This issue was highlighted at our last inspection and had not been addressed.
- Incident investigations were not completed in a timely manner. 28 incidents (21%) had occurred between March and September 2017 that had not yet been completed at the time of our inspection in October 2017.
- Only 8% of staff had received training on the use of the incident reporting system. Staff said that they did not always receive feedback about incidents that they had reported.
- There was low compliance in some areas of mandatory training, including Mental Capacity Act (64%), infection prevention and control (74%) and resuscitation training (75%) which was below the trust target of 90%.
- The emergency call bell system within nuclear medicine remained not fit for purpose, first identified in 2015. Call buttons were not always reachable from beds and alarms were not audible in some areas of the department. This was partially mitigated by staff regularly reviewing the patients in the department. There were plans to increase nursing hours in the bed bay to provide weekend cover but this was yet to be implemented

However:

- There had been improvements in staff understanding of the incident process.
- Progress had been made in the recruitment of new staff to address previously high vacancy levels.

Diagnostic imaging

Is the service effective?

We do not currently rate the effectiveness of diagnostic imaging services. However, we found the following areas of good practice:

- Appraisal rates were in line with trust targets and the service offered staff the opportunity for development and progression in their roles.
- The service was regularly reviewing the effectiveness of care and treatment through a comprehensive range of audits.
- The radiology department had achieved Imaging Service Accreditation Scheme (ISAS) re-accreditation in January 2017. This meant that the service had demonstrated organisation competence under four quality domains.
- Staff understood their roles and responsibilities under the Mental Capacity Act 2005. They knew how to support patients who lacked the capacity to make decisions about their care.

However:

- The diagnostic imaging service was not always meeting NHS England *Seven Day Services Clinical Standards*. However, there were action plans in place to work towards full compliance.
- Recommended changes to practice as a result of audit findings did not always identify the individual responsible for implementing changes or the date by which the change should have been implemented.
- There was mixed feedback about the effectiveness of multidisciplinary working between some staff groups.
- Mental Capacity Act (MCA) training compliance was 64.2%, which was below the trust target of 90%.

Is the service caring?

Good ●

We rated caring as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff provided emotional support to patients to minimise their distress. Link staff were available in diagnostic imaging areas to provide support to patients.
- Local patient surveys provided positive feedback.

However:

- Friends and Family Test scores were below the national average, and there were low response rates.

Is the service responsive?

Requires improvement ●

We rated responsive as requires improvement because:

Diagnostic imaging

- There were significant waiting lists for diagnostic imaging services, due to increased demand against capacity (8% growth per year), and waiting times for the completion of scans did not always meet internal targets.
- Reporting times were not meeting targets in the majority of diagnostic imaging areas.
- The facilities and premises for the cardiac catheter labs were insufficient to meet demand. Previous business cases had failed to progress due to physical and financial restrictions. Current revised plans were in place however extended facilities would not be completed until 2019.
- Data on waiting times was not formally recorded and therefore efficiency and areas for improvement could not be monitored and identified.

However:

- The service took account of patients' individual needs and offered out of hours, walk-in and one stop services to provide flexibility and choice.
- The service gathered the views of patients to assess whether services were being provided in a way that met their needs. Complaint responses were provided within policy timescales.
- The radiology department won a Health Enterprise East (HEE) award for an innovation designed to benefit patients in the service improvement category for their work on reducing the number of appointments missed through patients not attending.

Is the service well-led?

Requires improvement 

We rated well led as requires improvement because:

- Managers had not identified a number of concerns that were identified during our inspection and this indicated insufficient oversight of diagnostic imaging areas.
- Action had not been taken to address some of the concerns identified at our previous inspection. In addition, the concerns had not been added to the risk register to ensure that risks could be monitored and mitigated.
- Risks were not always resolved or acted upon in a timely manner and the risk register did not reflect all of the risks identified during this inspection.
- Ongoing monitoring of performance in the diagnostic imaging service was not effective. Audit cycles were not completed to allow review of impact of action and demonstrate improved practice.
- Staff did not always feel consulted on changes being introduced and morale had dropped as a result.
- The service was not always managing information effectively. There was no effective monitoring system to ensure incidents were closed in a timely manner and audit action plans were not always robust.

However:

- Strategic goals had been identified for the diagnostic imaging service and these were reviewed on an ongoing basis.
- The majority of staff were aware of the trust values and the future plans for the area in which they worked.
- Staff said that they felt proud to work in the organisation and described supportive relationships with colleagues.

Diagnostic imaging

- Staff said that their managers were approachable and supportive. None of the staff spoken to on this inspection raised concerns about bullying or harassment.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

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

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

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

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

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

This section is primarily information for the provider

Requirement notices

Regulated activity

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

Diagnostic and screening procedures

Family planning services

Management of supply of blood and blood derived products

Maternity and midwifery services

Surgical procedures

Termination of pregnancies

Treatment of disease, disorder or injury

Regulation

Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors

This section is primarily information for the provider

Enforcement actions

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

Regulated activity

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

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation

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

Our inspection team

The inspection was led by Tracey Wickington, Inspection Manager and Fiona Collier, Inspection manager. Fiona Allinson, Head of Hospital Inspection, and Heidi Smoult, Deputy Chief Inspector supported our inspection of well led for the trust overall.

The team included five inspectors and nine specialist advisers.

Specialist advisers are experts in their field who we do not directly employ.