We are the regulator: Our job is to check whether hospitals, care homes and care services are meeting essential standards.

Norfolk and Norwich University Hospitals NHS Foundation Trust

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We inspected the following standards to check that action had been taken to meet them. This is what we found:

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| Registered Provider | Norfolk and Norwich University Hospitals NHS Foundation Trust |
| Overview of the service | The Norfolk and Norwich University Hospitals NHS Foundation Trust provides a full range of acute clinical services, including some further specialist services. It has more than 6500 staff plus 600 volunteers that care for more than 700,000 people from Norfolk and neighbouring counties. |
| Type of service | Acute services with overnight beds |
| Regulated activities | Assessment or medical treatment for persons detained under the Mental Health Act 1983 |
| | Diagnostic and screening procedures |
| | Family planning |
| | Management of supply of blood and blood derived products |
| | Maternity and midwifery services |
| | Surgical procedures |
| | Termination of pregnancies |
| | Treatment of disease, disorder or injury |
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Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Norfolk and Norwich University Hospitals NHS Foundation Trust had taken action to meet the following essential standards:

- Respecting and involving people who use services
- Care and welfare of people who use services
- Cooperating with other providers
- Safety, availability and suitability of equipment
- Assessing and monitoring the quality of service provision

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 2 December 2013 and 3 December 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and received feedback from people using comment cards. We reviewed information given to us by the provider, reviewed information sent to us by other regulators or the Department of Health, talked with other regulators or the Department of Health and took advice from our specialist advisors. We were accompanied by a specialist advisor.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

This inspection had a variety of intentions. Firstly, we looked to see that the hospital had made improvements following our previous inspection undertaken in March and May 2013. During that inspection we found that the hospital was not ensuring the safe and timely discharge of people in their care. We also found that the hospital was not co-operating effectively with other providers to protect service users from potential harms. The provider was responsive to our concerns and forwarded us a report detailing the actions they were going to take in order to make improvements.

During this inspection our enquiries into these improvements demonstrated that the hospital had taken the necessary steps to safeguard people using the service. These systems were in their infancy but we were confident that the hospital would continue to make advances to better the service they provided.
In addition, following a review of information that we had received or gathered since January 2013, we identified other areas where we had concerns. We therefore undertook a detailed inspection into these areas. This included looking at how people and their representatives were kept informed about their care and treatment. We looked at how people’s dignity was maintained. We also assessed the availability of some equipment within the hospital and looked at the systems in place to demonstrate the hospital worked effectively.

We found that, in general, safe care was provided to the people using this service. Equipment (such as pressure mattresses) was usually available and where this was not staff within the hospital took necessary steps to ensure it was provided to the people who needed it as soon as possible. Quality assurance systems demonstrated that effective processes were in place to identify and deal with risks associated with the running of the service.

As part of this inspection we also looked at the quality of care provided to support patients with dementia to maintain their physical and mental health and wellbeing as part of a themed inspection programme. This programme looked at how providers worked together to provide care to people with dementia and at people’s experiences of moving between care homes and hospital. The evidence collected was used to inform the judgements we made in this inspection report. In addition we have produced a separate (annex) report summarising the evidence we collected that related to dementia care at the hospital.

You can see our judgements on the front page of this report.

**What we have told the provider to do**

We have asked the provider to send us a report by 02 April 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

**More information about the provider**

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.
Our judgements for each standard inspected

Respecting and involving people who use services  Action needed

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was not meeting this standard.

The registered person, had not, as far as reasonable practicable made suitable arrangements to ensure the privacy and dignity of service users or ensured that people, or those acting on their behalf, were given appropriate information about the care and treatment being provided to them.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Prior to this inspection we undertook an analysis of the information which we held about the hospital. Whilst reviewing concerns raised with us by members of the public we noted that in 21 out of 29 instances people were unhappy about how they were involved in their care, or that of a family member. Concerns were also raised about the level of respect shown to patients using this hospital. Examples of those concerns included a patient not being given appropriate information in relation to their on-going care needs and the timescales for follow up treatment. Various concerns were raised about a lack of respect with one person's next of kin reporting they were spoken to in an abrupt manner by a senior clinician. Two patients also reported that they had been unable to wash when they wanted to.

Therefore during this inspection we assessed how the hospital kept people up to date and involved with their health needs and maintained their dignity.

General observations showed that staff were kind, polite and patient. Good interactions between staff and patients were seen and these were well paced. One patient was seen to be distressed and was calling out about pain in their back. We observed that a nursing auxiliary spent time reassuring them and stroking their back and the patient calmed. Staff were heard referring to people by their preferred names. Curtains were pulled fully around beds for privacy and dignity when care was being given. We saw that support was being provided to those people who needed assistance with eating and drinking. For example, we saw people being given hand wipes before having their lunch.

However, we did observe various instances where people's dignity was compromised. For example, on one ward we saw a person walking around with their catheter bag clearly on
view around their ankle. Although staff were around on the ward, no one identified this or took action to help the person concerned. On another occasion, we observed a person walking around the ward with their back and buttocks exposed. We noted that the member of staff supporting them had not identified this and it took a senior member of staff to take action to protect this person's dignity.

On another, separate, occasion we observed a female patient who was on top of their bed with their nightgown around their waist and leg. We further observed staff walk past and make no attempt to protect their dignity. On a fourth occasion we observed another patient exposed from the waist down on their bed. They were attempting to cover themselves up but we could see their nightgown had become tucked underneath them. Again, staff were seen to walk past without offering assistance.

There was also mixed feedback from patients living with dementia about their experience of care. One person commented they were upset at having to wait to go to the toilet. Another person said, "Some [staff] are better than others at providing dignified care."

There were occasions when the privacy and modesty of people living with dementia had not been adequately preserved. One person, who was agitated and distressed in bed, was left with parts of their body exposed at times. Their bed was facing a nurse's station and although staff did make several attempts to cover them, they did not do this consistently and the person was left exposed at times in front of different healthcare professionals and visitors. One staff member we spoke with acknowledged that this person's care fell short of what should be expected because proper consideration had not been given about how their dignity could be supported, even in difficult circumstances.

The majority of staff communicated with people who had dementia in a respectful way, calling them by their preferred name and speaking with them directly and without patronising them. There was one exception to this when a staff member said that people with dementia were, "...like babies," because they had to work out what people's needs were. Whilst it was true that staff needed to try to understand the experience of people with dementia, comparing them to infants meant they were not shown due respect for their age and life experiences.

These observations were made on different wards throughout our inspection. This was half of the wards visited. We were therefore not confident that people would always have their dignity maintained whilst staying in this hospital.

We saw evidence of information for people and their visitors on all ward areas visited. For example, regarding hand hygiene, visiting times and contact telephone numbers. On one ward we saw extensive post-operative information for people and this was supplied to carers where applicable. Another example seen was comprehensive information regarding post-operative prophylactic thrombosis treatment (to prevent blood clots) for each person who had undergone major abdominal surgery. This had been drawn up in conjunction with the manufacturer of this specific treatment. Other discharge processes included ensuring that each person got a copy of their discharge letter and any other community services referral letter. However, the provider may find it useful to note that the information provided to people living with dementia was in a complicated format. Some people may have found this difficult to understand. Apart from a translation service, we did not see that people were provided with information about their condition and hospital stay in formats which were tailored to their needs. This meant that people with dementia may not have had access to important information about their care and welfare.
We asked people and their relatives about how they felt they were kept informed about their care needs. We spoke with 20 people using the service and 12 relatives. Whilst positive feedback about nursing staff and their compassion was received, mixed comments were received about how people were kept up to date about their or their relatives care.

One relative stated "They [the staff] could be better at keeping you informed, I often don't know how my [relative] is doing one day to the next and nor do they [in reference to their relative]". A patient told us that they had been waiting all day to receive a test and had been informed it was to be taking place at 10am. We spoke with this person at approximately 2:15pm, they had still not received their test and no one had been along to inform them of the delay.

On a second ward a relative told us that they had not been informed of their loved one's needs on the ward they were currently on, although on a previous ward communication had been good. On a third ward a patient and their relative commented that information about their care was not "...forthcoming..." and that they always had to request it. On two occasions we heard how a patient had been transferred between wards and their next of kin had not been informed.

On another ward we received mixed comments. One person told us "It's been really good; I know exactly why I am here." However another person's relatives commented "We're not sure why [my relative's] being kept in. We were told [they] would be here 24 hours and now it's been one week. Staff have not kept us informed." A second relative said, "Staff don't explain the treatment, so I ask [for the information]."

Similarly, the carer of a person with dementia and a history of recent admissions to the hospital told us they had not been involved or received any information from the staff when their relative was discharged on previous occasions.

On three separate instances during this inspection people raised concerns with us that their personal belongings were not being transferred with them when they moved between wards. One person told us their belongings had been "...lost..." for a day. These included their spectacles, medication, nightwear and Kindle. This had caused a great deal of distress as they had not been able to see clearly and had to use hospital nightwear. Following our inspection we also received another concern from a person's relative which stated that their relative's belongings had not been sent home with them on discharge.

However on other wards we visited we received no negative feedback. We spoke to a visiting relative who spoke highly of the care and treatment provided by the nurses and the medical staff. They reported that they visited frequently and had been involved in discussions with the relevant clinicians about the care and treatment that their relative was receiving. On another occasion a person's relative commented "It's been really good, I've not had any problems; They've kept me as informed as possible I think." A patient commented "They've [the staff] been great, I can't fault them; I know what I'm here for."

Other people told us that they were happy with the level of care and support provided by nursing and medical staff. One person told us that, "The staff are friendly and will answer any queries that I have." Someone else said, "The staff are all good." Another person told us that, "If I have any questions the staff will answer these."

Again, these comments were made across different wards throughout our inspection.
However, due to the variance in feedback we received we are not confident that people, or their representatives, will always be kept up to date about their care needs.
Care and welfare of people who use services  

Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people’s safety and welfare.

Reasons for our judgement

During this inspection we looked at various aspects of the care provided within the hospital. We looked at the provision of care in relation to people living with dementia and we looked to see that improvements had been made to the discharge process, following concerns found during our previous inspection in May 2013. We also assessed the quality of the admission process.

We used our Short Observational Framework for Inspection (SOFI) tool during the inspection. The SOFI tool allows us to spend time watching what is going on in a service and helps us to record how people spend their time, the type of support they get and whether they have positive experiences.

We spoke with 12 people living with dementia during this inspection. Many of the people we spoke with reported that although staff were very busy and had little time to give to them, they were mostly happy with the care provided. One person said, "Some nurses are good at noticing what you need. You don't have to ask".

We saw that most patient areas which met the needs of older people had a dementia lead who had additional knowledge of the condition and the effect it may have on people. The dementia leads supported staff to understand how best to support people with dementia. We observed that most staff showed kindness and sensitivity toward the people they were caring for. We saw several staff members taking turns to be with a person who used the service who walked and verbalised continuously. The staff talked to them calmly and warmly. We saw a nurse sitting with a person who used the service and who was agitated. We noted that their presence and approach had a calming effect.

Using the SOFI we saw that staff worked hard to be available to people who used the service when they were needed. However we saw that this was not always possible. Sometimes staff had to react to situations, such as providing support to people with dementia who were stating they wanted to go home. They did this with compassion and concern for people's well-being. Most people responded positively to staff although others could not be pacified despite the staff's best efforts. Some staff recognised the limitations of their knowledge of dementia and were concerned that they could not adequately help people who were distressed. The provider may find it useful to note that these staff said...
they would like more training to understand how best to support people with dementia when they expressed distressed behaviours.

We were told that the hospital security staff were often called to help manage people with dementia when the ward staff required assistance. The security staff worked in pairs and we were told how this could be intimidating to people with dementia. One member of staff said, in their professional opinion, "They [some security staff] don't understand how to communicate with people with dementia."

We therefore spoke with security staff who told us that if the physical restraint of a person with dementia was required they would first discuss the situation with the clinical staff and check that a mental capacity assessment had been made. The ward staff we asked did not know what the hospital policy was on the use of non-clinical staff to manage the distressed behaviours of people with dementia.

We raised this issue with the trust management during our inspection and asked them to provide evidence which demonstrated that their security staff were adequately trained to understand how to meet the needs of people with dementia who were displaying behaviours that challenged. We were provided with a course summary which all security staff had attended called 'Restrictive Physical Intervention'. This included the use of non-physical interventions. The provider may find it useful to note however that we found no reference to security staff having received training specifically on the management of behaviours by people with dementia although this was asked for. The lack of training for security staff who were expected to work alongside the ward staff to manage the behaviours of people with dementia that challenged increased the risk that the needs of people with dementia may not be appropriately understood and met.

In relation to the follow up aspects of our inspection we found that necessary improvements had been made. In May 2013 we raised concerns in relation to the quality of discharge planning. For example, we found that discharge planning documentation was not being completed to demonstrate that people's needs had been appropriately managed.

Following this inspection, the hospital management team developed an action plan and told us what they were going to do in order to make improvements. This included the review and changes already developed by the Trust to the discharge planning process and nursing documentation.

During this inspection, carried out on 2 and 3 December 2013, we saw that a new discharge process was being implemented and we noted that new paperwork was in place. Staff on the hospital wards confirmed that they had been engaged in the development of this system. We also saw that a new 'transfer of care' document had been developed. This document was developed following consultation with residential and nursing home managers. The purpose of this document was to enable key information to travel with patients when they transfer between care services.

To ensure that continual improvements to the discharge process were made we noted that a system for reporting poor discharges had been set up. This meant that other care providers could easily report any issues arising from a person's discharge from hospital. We were provided with evidence which demonstrated the hospital was monitoring the discharge process. This included ensuring poor discharges were investigated and reported on.
Whilst at the time of our inspection these systems were not fully embedded, we were confident that improvements had been made. This meant that the care being provided was safe.

In relation to the admission process, we found that some areas of the hospital managed this better than others. In the ward areas we reviewed the documentation for 27 people receiving care and treatment. The majority of these records demonstrated that appropriate assessments were undertaken on admission in relation to people's physical health needs. However, the provider may find it useful to note that we found information in relation to people's social and emotional needs was not routinely documented, particularly in relation to patients with dementia.

The hospital had a dementia screening assessment to be undertaken when older people were admitted. This helped to ensure that people's cognitive functioning was appropriately assessed. If necessary, a referral was then made to specialist services such as the Memory Matters team who would undertake a specialist assessment of the person's needs. We spoke with a member of the Dementia Intensive Support team (DIST) who also assessed people with memory issues and liaised with other professionals to agree the level of support required by people with dementia and their carers following discharge. This meant that systems were in place to identify and assess people with dementia early and help support their plans for their future needs.

We saw a nursing assessment which included a section for the person using the service to explain what they would like staff to know about them and who in their life was important to them. The nursing assessments were based on activities of daily living (ADL). ADL assesses a person's level of functioning in different areas such as mobility, mental health and communication. People's needs were mainly identified by a series of tick boxes. However, there was little space to provide a more detailed description of the person's needs and preferences. This increased the risk that people's needs may not be fully understood and met.

For example, during our SOFI we saw that one staff member was finding it a challenge to support a person who was disorientated and agitated and wanting to leave the ward. The staff member said they knew nothing about the person's background or preferences. They tried to understand the experience of the person by observing their reactions. They then used this information alongside memory prompts and activity to try to calm the person and we saw this had a positive effect on their well-being at times.

Some files contained assessments by the Memory Matters team, others contained no formal assessments of the cognitive ability of people with dementia. Some assessments described people as, "...pleasantly confused..." or "...very confused." These generic terms provided limited insight into the experience of people with dementia and how this may affect their level of functioning. We saw that booklets, called "This is Me," were available to be completed with information on the person's background, their needs, preferences, likes and dislikes and interests. Few of these booklets had been completed however.

We looked at how people's holistic needs were assessed by a range of healthcare professionals. We noted that physiotherapists responded quickly to referrals to assess people and prioritised those who were ready to be discharged. Their assessments considered the non-verbal signs of pain. This meant that assessments were done to recognise pain and discomfort in people who were less able to communicate verbally.
In other care plans reviewed we read detailed information about why people had been admitted to hospital. We saw risks assessments completed on falls, nutrition and pressure area care. The records had been checked and dated. We noted that venous thromboembolism (VTE) assessments had taken place and these were attached to the relevant medicine administration record (MAR). We saw that where required additional care plans had been drawn up in the majority of cases. For example we saw two wound management care plans. These had been evaluated following each episode of wound care and reviewed as required by the clinical team. The provider may find it useful to note that in three instances we found examples of where care plans had not be written to meet the individual needs of people using this service.

Systems were in place for the identification of the deteriorating patient. For example, we saw that the trust used the early warning signs (EWS) system based on the recorded observations of each person's physical health. We saw that medical staff were available on each ward area and that each person was reviewed on a daily basis by their relevant medical team.

However, the provider may find it useful to note that our review of records in the accident and emergency department (A&E) demonstrated that not all paperwork was being completed properly. For example, on a number of occasions we noted that information about people's allergies had not been documented. People may not have had an allergy but without information confirming this, there was a risk that people may not have received appropriate care or treatment. We also found that handover from A&E to the ward areas did not always take place.
Cooperating with other providers

People should get safe and coordinated care when they move between different services

Our judgement

The provider was meeting this standard.

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

Reasons for our judgement

During this inspection we looked at how this hospital cooperated with other providers. We looked at how this was managed in relation to people living with dementia. We also looked to see that improvements had been made following concerns found during our previous inspection in May 2013.

Once admitted to this hospital, people had access to assessments and support from a range of health and social care professionals including the Memory Matters team, the Dementia Intensive Support team (DIST), physiotherapists and social workers. We saw that a physiotherapist had assessed a person’s mobility and had recommended they be discharged with a new walking aid. The physiotherapist contacted the care home where the person lived to check they would be able to manage their increased needs. They also arranged for the community physiotherapist to visit the person after discharge to continue their treatment in the community. Several staff told us this system was valued and worked well.

We saw the involvement of the First Support team that provided intensive support to people when they first left hospital. We also saw that people's continuing care needs were assessed for nursing care. One record showed that discharge plans to a care home with nursing were in place where the person's increased level of needs could be supported.

We saw that discharge letters were prepared summarising the person's stay in hospital and confirming what their care and treatment needs were. One copy was given to the person using the service and another to their GP. We were told that a workshop had been held between the hospital staff and care home providers which had triggered better discharge planning. This had led to agreements that ambulances would be booked earlier in the day and the care home would be contacted in advance to agree the discharge arrangements. This meant that people who used services could be more confident that their discharge plans would be effective.

The DIST liaised with professionals across health and social care services and helped to facilitate on going assessment of need. They helped to set up packages of care designed to support people's return home where this was possible. Although the DIST mainly
supported people who were returning to their own home, they also helped to set up placements in care homes. Staff told us this referral pathway worked well and was beneficial to the people who used the service. The DIST provided information to care homes about people’s needs and were available by separate referral to work more closely with care homes to improve support for people with dementia. The DIST also provided training, advice and guidance to develop skills to understand and care for people with dementia.

A family member commented on the treatment of their relative at the hospital stating this had been, “…very good.” The person had been admitted from a care home with dehydration, malnutrition and infections and by comparison the relative said the hospital treatment had been, “…first class.” The person was not returning to the care home and an alternative placement was being planned.

The Nursing Assessment and Plans of Care document included a discharge checklist which confirmed the referral arrangements made to other health and social care providers and the equipment needed to enable a safe discharge.

In relation to the follow up aspects of our inspection we found that necessary improvements had been made.

In May 2013 we raised concerns in relation to the processes in place which allowed the hospital to effectively cooperate with other providers. We found this had a negative impact on the people using this service. For example, we found that people were being delayed in various parts of the hospital when they were assessed as medically fit for discharge. We also found that on occasion people had to wait considerable amounts of time to be transferred from ambulances to the emergency department.

Following this inspection, the hospital management team developed an action plan and told us what they were going to do in order to make improvements. This included improving systems within the accident and emergency department (A&E) to improve ambulance handover times and better working with other providers to improve the discharge process.

We spent some time talking with the director of emergency services who told us about action which had taken place in order to improve the service within the A&E. We were told, and saw, that an Immediate Assessment Unit (IAU) had been developed. We saw an implementation plan in place which demonstrated how this service was to be put in place over time. At the time of our inspection this service was functioning Monday to Friday 9am to 9pm. We saw that recruitment had taken place in order to increase medical decision making capacity and to enable the IAU to operate 7 days per week. Staff we spoke with in the A&E department confirmed that the initiation of the IAU had improved the service they were providing.

We were also provided with an update with regards to the planned extension of the A&E department. From January 2014 an urgent care centre was to be piloted. The pilot was to last three months and to be run by general practitioners and community nurses. It was envisaged that this project would increase capacity within the A&E department to deal with medical emergencies.

Prior to our inspection, we noted that there were differences between the ambulance handover data reported by the hospital and that which was being reported by the East of
England Ambulance Trust. For example, in October 2013 the hospital reported that on eight occasions they were responsible for people waiting more than 30 minutes in an ambulance before being transferred into A&E. However, the ambulance trust reported that their ambulances waited at the trust for more than 30 minutes on over 300 occasions during that month. We asked the director of emergency services about the reasons for such anomalies. We were told that there were issues with two computer systems being able to track patients accurately. We were also told that reported figures by the ambulance trust included all ambulance arrivals to the hospital, for example, non-emergency arrivals to maternity services and other wards.

The director of emergency services told us that the hospital had developed a validation system which meant that their reporting figures were accurate for ambulance arrivals at the A&E department. Following our inspection we checked with the ambulance trust that they supported this validation system. We were told that they had worked with the hospital management team in order to make improvements and supported the validation system in place. We were further told of the on-going work between the two organisations in order to further improve the sharing and corroboration of data.

To help with the accuracy of data reporting we saw that a hospital ambulance liaison officer (HALO) was in place on A&E. The HALO was employed by the ambulance trust and their role was to monitor ambulance wait times and escalate potential delays. On the whole the HALO felt their role was having a positive impact on the delays seen in A&E, as did other members of staff. However, the provider may find it useful to note that there was some confusion about who was responsible for updating the system when patients were 'cleared' from ambulance trolleys. We were told that this occasionally impacted on the accuracy of data collected.

We spoke with the head of delayed transfers of care who told us about the work they had been undertaking in order to improve the discharge process. We saw evidence that regular meetings had been taking place with the community trust, social services and other relevant providers such as Age UK. A discharge newsletter had been developed. The purpose of this was to keep both staff and providers in the wider healthcare system up to date about improvements being made to the hospital's discharge process.

We saw that a lot of work was being undertaken to ensure that all services could continue to meet the needs of people during the winter period. Action plans were in place and regular cross-provider meetings were being held to discuss issues and potential risks. We also noted that the hospital had been working collaboratively with other providers under 'Project Domino'. This project was aimed at improving the local healthcare system by refining services to allow people to move from acute medical services in a safe and timely way.
Safety, availability and suitability of equipment  Met this standard

People should be safe from harm from unsafe or unsuitable equipment

Our judgement

The provider was meeting this standard.

People were protected from unsafe or unsuitable equipment.

Reasons for our judgement

Prior to our inspection, we carried out an analysis of the information that we held about the Norfolk and Norwich Hospital. Whilst reviewing incident analysis we noted that on occasion the reporting of pressure sores included information which stated pressure relieving equipment such as air mattresses were not always available on time, when people needed them.

We therefore, during this inspection, assessed the availability of equipment, particularly in relation to air mattresses, within the hospital. The majority of wards visited confirmed that there was, on occasion, a problem with people receiving equipment they needed in a timely way. On one ward we spoke with two members of staff who said it can take a couple of days, at times such as weekends and bank holidays, to get the equipment people needed. We were however assured by staff that occasions when people had to wait excessive periods of time for equipment were rare.

We noted on the day of our inspection on one ward, we noted that a person had been assessed as needing pressure relieving equipment but had not received it. They had been waiting for three days. However, we later checked the person had received the mattress and found they now had one in place. The provider may find it useful to note that when speaking with a member of staff about this patient we were told they had scored over 18 on their pressure area (waterlow) assessment. They told us that anyone who had a score of 18 or above would require a special pressure relieving mattress. However, on other occasions during our inspection we were told that a waterlow score of 20 or above was the threshold for a person requiring pressure relieving equipment. The hospital management team confirmed that the correct threshold was a score of 20 or more. This meant the patient above was not an immediate risk and the delay in receiving pressure relieving equipment was unlikely to have had a negative impact on their welfare.

We found no other concerns in relation to people not having the correct pressure relieving equipment in place during our inspection. However, on one ward there was a day room that should have been available for people on the ward to use as they wished. We found this room full of high backed chairs. We were told this was due to a warning circulated on 6 November 2013 telling ward staff to check these chairs and remove them if they had any damage. In the almost four weeks since the chairs were removed (approximately 10 were placed in the day room with stickers on stating 'do not use') people did not have a bedside chair to transfer to. We spoke to the nursing staff and physiotherapist who informed us
some people had remained in bed who could have transferred to their chair if one had been available. They told us that muscle tones were possibly being affected and people’s risk of acquiring a pressure sore had increased. However, we asked to see pressure sore information from the month prior to the chairs being removed and the current month. These records did not show an increase in the number of pressure sores being reported. This indicated that staff were appropriately managing the risks associated with removal of the chairs.

We highlighted this issue to the hospital management team during our inspection and asked them to investigate the matter further. We were told prior to the end of our inspection that no patients had been placed at risk because chairs were being rotated around the ward or taken from other areas of the hospital. Following our inspection, a formal report was forwarded to us, which again stated that people had not been placed at risk. We were provided with assurances that a programme to replace the chairs on this ward was in place.

We were provided with an order sheet which confirmed that the hospital had hired bariatric (for use with obese patients) equipment when this was needed. We asked for an incident analysis of all reported equipment issues from January 2013 to November 2013. In October 2013, 15 incidents were reported where a pressure mattress was not immediately available to people who had been assessed as needing one. However, we were provided with evidence, in the form of e-mails and reports, which demonstrated that hospital staff worked to ensure that pressure mattresses were found and allocated as necessary.
Assessing and monitoring the quality of service provision

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

During this inspection we looked at how this hospital monitored the quality of the service it provided. We looked to how this was managed in relation to people living with dementia and we looked to see that systems for other parts of the hospital were in place.

We were provided with evidence which demonstrated auditing was taking place in relation to dementia care at ward level. One audit was titled 'Dementia – an audit of care versus national dementia audit guidelines'.

In relation to reporting of progress against its Annual Clinical Audit Plan, the provider may find it useful to note that we could not be assured of the effectiveness of its monitoring. For example, we noted that three quarters of the way through the year a large amount of clinical audits were being reported as not yet complete. We were made aware that some of these audits are on-going from year to year and so are only recorded as completed at the close of each year. It was not clear from the clinical audit plan, however, which ones these were.

In addition to ward level monitoring, the trust also took part in the Royal College of Psychiatrists (RCP) 'National Dementia Audit'. We were provided with a copy of the last report dated February 2013 and noted that the hospital performed well in the majority of the areas assessed, compared to national averages. We were told that the hospital intended to take part in the next national audit commissioned by the RCP.

The trust had also implemented a dementia strategy and held various meetings within four work streams to monitor the effectiveness of dementia care. These work streams included looking at how the patient was cared for, how education was provided to staff to help care for people with dementia, how the environment met the needs of people with dementia and how research was used to continually improve dementia care within the trust. Senior members of staff also took an active part in the 'Norfolk Dementia Project Group' and annual meetings on the dementia strategy were held for all staff at the Trust to attend.

We reviewed the trust's board assurance framework (BAF) and noted that various corporate deliverables (targets to avoid known risks) had been identified to ensure that
minimum standards were implemented to meet the needs of people living dementia. We saw that risks had been identified, which may have impacted on the trust being able to achieve its aims. We also saw that to monitor those risks, assurances were sought from within the trust and these were continually reviewed.

The provider may however find it useful to note that learning from the analysis of significant events that may have had a negative impact on people using the service was not available to the Memory Matters team and DIST because they worked for a different trust.

We spoke with ward staff who told us that to monitor the care they were providing to people living with dementia they asked people for feedback. We were told that these systems were in their infancy as it had been hard to gather meaningful comments. We were told about a carer's audit which had been trialled and which only got a 10-15% response. We were told that the trust was working with other agencies such as Age UK and Memory Matters in order to develop meaningful feedback techniques for people living with dementia. We saw that on each ward a "Friends and Family Test" had been initiated. This involved asking patients on their day of discharge how likely they were to recommend the ward to friends and family. We saw that the results from across the hospital, including dementia wards, were collated and discussed at the Trust Board. We saw that where negative scores were received, the director of nursing spent time planning improvements with the wards concerned.

In relation to other areas of the trust we found that effective monitoring systems were in place.

There was evidence that learning from incidents took place and appropriate changes were implemented. We spent some time reviewing the incident reporting system in place at the hospital. We asked for a series of reports which would demonstrate that appropriate incidents were reported. We saw the system the hospital had in place allowed it to analyse incident trends and take action where necessary. For example, we saw that falls incident data was regularly reviewed and that the falls steering group reviewed the information to assess where improvements could be made.

We further noted that all serious incidents had a root cause analysis undertaken and that the results of and learning from these were disseminated throughout the Trust. For example, we saw all serious incidents and their outcomes were reviewed by the Trust Board on a monthly basis through a patient safety and quality report. We also reviewed the clinical governance minutes of the older people's medicine division and saw that incidents and learning outcomes were discussed at a more localised level.

The provider took account of complaints and comments to improve the service. We spoke with the head of legal services about the complaints system. We saw that on a regular basis reports were completed which looked at the key themes and issues arising out of complaints made about the trust. The trust also undertook a survey to find out if people were satisfied about the response they had received to their complaint. We saw results which demonstrated that the majority of people had been satisfied with the way in which trust had handled their complaint.

However, when we asked to review the system for ensuring that patient advice and liaison (PALs) comments were acted upon, we were not assured that the Trust acted on these appropriately. For example, we asked for a report which demonstrated that key themes and issues were considered. We were provided with a report dated 4 April 2013 which had
“draft” written across the top. When we asked for evidence which demonstrated this report had been discussed within the Trust, we were not provided with any. We were however provided with a later report which was due to be discussed in December at the patient experience working group.

We reviewed the audit programme in place. We noted that the trust had a system in place which allowed it to assess its compliance with the Care Quality Commission’s essential standards of quality. We saw that these audits took place with both internal and external professionals. Regular reporting took place which was reported to both the Trust Board and divisional teams within the hospital.

We reviewed the trust’s risk register for high level risks. We noted that this was reviewed on a regular basis and that actions were being taken to reduce identified risks. For example, in one of its departments the hospital was not staffed in line with national recommendations. We saw that this issue had been highlighted and that recruitment was being undertaken and monitored.

To enable each ward area and department to understand its performance, we saw that a nursing dashboard had been put in place. This dashboard contained details of incidents reported, the number of complaints received, the outcomes of audits and performance data against key indicators for each area. This information was clear and allowed staff to see where improvements were needed. Senior staff on the wards told us that the director of nursing regularly discussed this dashboard with them. This meant that systems were in place which allowed each area to monitor the quality of service it provided.

We noted that the issues highlighted above had already been recognised by the hospital management team. We saw that in October 2013 a new governance structure had been approved for implementation from January 2014.
This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td></td>
<td>Respecting and involving people who use services</td>
</tr>
<tr>
<td></td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>Regulation 17 (1) (a) and (b).</td>
</tr>
<tr>
<td></td>
<td>The registered person, had not, as far as reasonable practicable made suitable arrangements to ensure the privacy and dignity of service users or ensured that people, or those acting on their behalf, were given appropriate information about the care and treatment being provided to them.</td>
</tr>
</tbody>
</table>

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 02 April 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.
About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.
## How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

<table>
<thead>
<tr>
<th>Met this standard</th>
<th>This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action needed</td>
<td>This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.</td>
</tr>
<tr>
<td>Enforcement action taken</td>
<td>If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.</td>
</tr>
</tbody>
</table>
How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

**Minor impact** - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

**Moderate impact** - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

**Major impact** - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.
Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our Guidance about compliance: Essential standards of quality and safety. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the Guidance about compliance. The 16 essential standards are:

<table>
<thead>
<tr>
<th>Standard</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respecting and involving people who use services - Outcome 1</td>
<td>Regulation 17</td>
</tr>
<tr>
<td>Consent to care and treatment - Outcome 2</td>
<td>Regulation 18</td>
</tr>
<tr>
<td>Care and welfare of people who use services - Outcome 4</td>
<td>Regulation 9</td>
</tr>
<tr>
<td>Meeting Nutritional Needs - Outcome 5</td>
<td>Regulation 14</td>
</tr>
<tr>
<td>Cooperating with other providers - Outcome 6</td>
<td>Regulation 24</td>
</tr>
<tr>
<td>Safeguarding people who use services from abuse - Outcome 7</td>
<td>Regulation 11</td>
</tr>
<tr>
<td>Cleanliness and infection control - Outcome 8</td>
<td>Regulation 12</td>
</tr>
<tr>
<td>Management of medicines - Outcome 9</td>
<td>Regulation 13</td>
</tr>
<tr>
<td>Safety and suitability of premises - Outcome 10</td>
<td>Regulation 15</td>
</tr>
<tr>
<td>Safety, availability and suitability of equipment - Outcome 11</td>
<td>Regulation 16</td>
</tr>
<tr>
<td>Requirements relating to workers - Outcome 12</td>
<td>Regulation 21</td>
</tr>
<tr>
<td>Staffing - Outcome 13</td>
<td>Regulation 22</td>
</tr>
<tr>
<td>Supporting Staff - Outcome 14</td>
<td>Regulation 23</td>
</tr>
<tr>
<td>Assessing and monitoring the quality of service provision - Outcome 16</td>
<td>Regulation 10</td>
</tr>
<tr>
<td>Complaints - Outcome 17</td>
<td>Regulation 19</td>
</tr>
<tr>
<td>Records - Outcome 21</td>
<td>Regulation 20</td>
</tr>
</tbody>
</table>

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.
Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term ‘provider’ means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a ‘service’.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.