Care Quality Commission

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

Inspection report

Queen Elizabeth Hospital
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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 Queen Elizabeth Hospital King's Lynn is an established 488 bed general hospital on the outskirts of King's Lynn, Norfolk. It provides healthcare services to West and North Norfolk in addition to parts of Breckland, Cambridgeshire and South Lincolnshire. The population of this area is approximately 331,000 people. The population profile includes a high proportion of older residents; however, new housing developments in recent years have seen large population growth of principally young families.

The trust provides a comprehensive range of specialist, acute, obstetrics and community-based services. The trust works with neighbouring hospitals for the provision of tertiary services and is part of regional partnership and network models of care, such as the trauma network.

Some specialist services and clinics were provided in community facilities, such as the North Cambridgeshire hospital in Wisbech and St Georges Medical Centre in Littleport.

Between March 2017 and February 2018 there were:

- 78,325 inpatient admissions
- 324,655 outpatient attendances:
- 64,783 accident and emergency attendances

The trust achieved Foundation Trust status in 2011.

The trust is part of the Norfolk and Waveney Sustainability and Transformation Plan (STP).

The trust is commissioned by clinical commissioning groups from three counties. The lead commissioner is West Norfolk Clinical Commissioning Group.

We carried out a comprehensive inspection at the Queen Elizabeth Hospital King's Lynn NHS Foundation Trust in July 2014, where the trust was rated requires improvement overall and remained in special measures. We then carried out a scheduled focused inspection in June 2015 to review services that had previously been rated as requires improvement or inadequate and to consider the status of the trust in relation to special measures. The trust had two outstanding warning notices in relation to safeguarding (safe and ethical restraint) and medicines management which were reviewed as part of this inspection. We judged that the trust was now meeting the requirements under the regulations and therefore we removed the warning notices. The trust had made significant improvement at that time and were rated as requires improvement overall and was recommended to come out of special measures.

We inspected the trust between the 4 April and 24 June 2018. Core services inspected were medicine, inspected between 4 and 6 April 2018, urgent and emergency care, surgery, maternity, end of life, outpatients and diagnostic imaging on 1 and 2 May 2018. A well led inspection at provider level took place between the 19 and 21 June 2018. We also undertook two further unannounced inspections on 18 April and 10 May 2018 to follow up on concerns.

Overall summary

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

Summary of findings

What this trust does

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust provides a comprehensive range of specialist, acute, obstetrics and community-based services. Services are provided at The Queen Elizabeth Hospital in King's Lynn and some specialist services and clinics are provided in community facilities, such as North Cambridgeshire hospital in Wisbech, Fakenham Medical Centre, Swaffham Community hospital and St Georges Medical Centre in Littleport.

Services provided at The Queen Elizabeth Hospital include urgent and emergency care, medical and surgical care, critical care, maternity and gynaecology, neonatal and paediatric care, end of life care, outpatient services and diagnostic services.

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 scheduled focused inspection in June 2015 we undertook enforcement action and told the trust it must take action to improve.

CQC served three Requirement Notices; one in relation to Regulation 12, Health and Social Care Act (HSCA) (RA) Regulations 2014 Safe care and treatment. One in relation to Regulation 17 HSCA (RA) Regulations 2014 Good governance. The other was in relation to Regulation 18 HSCA (RA) Regulations 2014 Staffing.

We inspected the trust between the 4 April and 21 June 2018. Core services inspected were medicine, inspected between 4 and 6 April 2018; urgent and emergency care, surgery, maternity, end of life, outpatients and diagnostic imaging on 1 and 2 May 2018. A well led inspection at provider level took place between the 19 and 21 June 2018. We also undertook two further unannounced inspections on 18 April and 10 May 2018 to follow up on concerns.

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 The Queen Elizabeth Hospital King's Lynn 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.

Summary of findings

The Queen Elizabeth Hospital

- Urgent and Emergency care was rated as inadequate overall. The ratings for safe, effective, responsive and well-led all went down, whilst caring remained good. Effective and responsive went down from good to requires improvement. Safe went down from requires improvement to inadequate and well-led went down from good to inadequate. The service did not always have systems in place to ensure that staff were able to identify and respond appropriately to changing risks to people who used services. The design and use of facilities and premises in the emergency department did not always keep people safe. The numbers and skill mix of nursing and medical staff were not always suitable for the needs of the emergency department. Learning from serious incidents was not always robust. A significant number of clinical guidelines were out of date for review. Performance in national audits was mixed and there was limited evidence of learning and action when national audit results were in the lower UK quartile. We were not provided with evidence that urgent and emergency services were following a trust-wide process to ensure that compliance with new or updated National Institute of Health and Care Excellence (NICE) guidance was regularly reviewed. There were a number of factors impacting on flow through the department and policies in place to manage escalation and crowding lacked clarity. Leaders had not always taken action to address concerns and learning from external reviews was not effectively used to make improvements. There were not always robust arrangements for risk or information management. However, medicines storage and compliance with hand hygiene had improved since our last inspection. Staff were knowledgeable about the Mental Capacity Act and about how to respond if a patient complained. There was a positive culture and leaders were perceived to be visible and supportive.
- Medical care was rated as inadequate overall. The question of safety went down from requires improvement to inadequate. Effective, caring and responsive all went down good to requires improvement. Well led went down from good to inadequate. Staff turnover, sickness and vacancy rates were higher that the trust targets. There was evidence that low nurse staffing levels were impacting on patient safety because staff did not have capacity to assess patient risk and meet basic food, drink and toileting needs promptly. Medicines management processes were not robust and patient records were poor in their completion and clarity. There was limited evidence that audit results were acted upon as a means of continuous quality improvement for the service. Staff knowledge of mental capacity assessments was poor and mental capacity assessments were not being completed appropriately and consistently. Although staff displayed a kind, compassionate and dedicated approach to patients and relatives, they did not have the time or capacity to provide the level of support they would like. Access and flow was not being effectively managed. Services were not always delivered in a way that was responsive to people's individual needs. Poor support and communication from the trust senior team had led to a poor culture and morale, with staff feeling disengaged and under pressure. Arrangements for governance and risk management were not robust.
- Surgery services went down from good to requires improvement overall. The questions of safety, effectiveness, responsive and well led went down from good to requires improvement. The question of caring remained rated as good. Mandatory training compliance was below target levels and some staff did not follow infection prevention and control procedures. Records were not stored securely on all wards and we had concerns relating to the safe management of medicines. We were not assured that incidents were always identified, reported and investigated in a timely way or that duty of candour requirements were consistently met. Staff did not always understand or correctly implement the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff appraisal rates were below target and implementation of local clinical audit was variable. Access and flow was not always managed effectively, services were not always planned to meet patients' needs, and the documentation of patients' individual needs was not always completed in a timely way. There was no vision and strategy in place for the service and there were concerns around governance processes relating to sharing of information, risk management and performance reporting. Staff gave variable feedback on the response of leaders to their concerns. However, staff treated patients with kindness and compassion and there were improvements in relation to decontamination of cystoscopes and the consultant rota for gastric bleeds.

Summary of findings

- We rated maternity as inadequate overall. We rated safe, responsive and well led as inadequate, we rated effective as requires improvement and caring remained rated as good. There were concerns relating to the safety of the service in respect of risk assessment procedures for the environment, care planning for high-risk women, equipment and emergency medicines monitoring and mandatory and safeguarding training compliance rates. We found that leadership within the service had broken down and that the service's leaders did not have oversight of risk or quality improvement within the service.
- End of life care remained rated as requires improvement overall. Safe went down from good to requires improvement, effective went down from good to inadequate, well-led stayed requires improvement, responsive improved from requires improvement to good 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 was lack of assurances that the Mental Capacity Act and Deprivation of Liberty Safeguards were always being implemented for people who had DNACPR documentation. The end of life care strategy was ratified in February 2018 and therefore had not been embedded fully. Implementation of the end of life care strategy and various initiatives such as the amber care bundle and the IPOC have been very slow due to lack of engagement from the medical team. In addition, due to staff shortage on the wards, training had to be cancelled, which meant the IPOC had not been fully rolled out or effectively used.
- Outpatient services were rated as requires improvement overall. Safe, responsive and well led were rated as requires improvement and caring was rated as good, effective is not rated. We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings There were concerns related to the performance in areas such as infection prevention and control, mandatory training, safety checks prior to minor procedures and resuscitation equipment. There was a lack of performance and patient outcome audit, and processes to improve the service. Leadership was not robust with a lack of oversight of governance and risk to the service and poor senior leadership engagement. However, the service had a better than England average percentage for two-week cancer referrals and feedback from patients was positive.
- Diagnostic imaging was rated as requires improvement overall. The question of safety, responsive and well led were rated as requires improvement. Caring was rated good, effective is not rated. We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings. There was a potential risk of abuse to patients and staff as chaperones were not routinely offered or provided during intimate imaging procedures. Services did not meet the needs of local people as patients were unable to access diagnostic imaging services in a timely manner and we were not assured the service had robust structures, processes and systems in place to support the delivery of high quality person centred care especially in the radiology department. However, the service held Imaging Services Accreditation, (ISAS), provided care and treatment based on national guidance and carried out audit to monitor the effectiveness. Feedback from patients confirmed that staff treated them well and with kindness.
- On this inspection we did not inspect critical care and children and young people services. The ratings we gave to these services on the previous inspection in the comprehensive inspection in June 2015 and focused inspection in June 2016 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 safe. The service did not always have systems in place to ensure that staff were able to identify and respond appropriately to changing risks to people who used services. The design and use of facilities and premises in the emergency department did not always

Summary of findings

keep people safe. The numbers and skill mix of nursing and medical staff were not always suitable for the needs of the emergency department. The trust target for mandatory training completion had not been met for any of the 10 mandatory training modules. Learning from serious incidents was not always robust. However, medicines storage and compliance with hand hygiene had improved since our last inspection.

- Medical services had gone down for safety from requires improvement to inadequate. Staff turnover, sickness and nurse vacancy rates were higher than the trust targets. There was evidence that low nurse staffing levels were impacting on patient safety because staff did not have capacity to assess patient risk and meet basic food, drink and toileting needs promptly. The trust used a high proportion of agency nurses to fill gaps in rotas, including occasions where wards were entirely staffed by agency nurses on night shifts. Medicines management processes were not robust and staff felt there was a high rate of medicines incidents, in part due to insufficient staff numbers. National Early Warning Scores (NEWS) were not completed consistently, and appropriate escalation did not always take place. Checks on resuscitation trolleys were not consistently carried out and documented. There was no resuscitation equipment available in the discharge lounge at the time of inspection. Patient records were poor in their completion and clarity. Feedback and learning from incidents was not consistently shared.
- Surgical services went down from good to requires improvement for safety. Mandatory training compliance was below target levels and some staff did not follow infection prevention and control procedures. We had concerns about arrangements for disposing of waste on Elm ward and the surgical assessment unit. There were some gaps in procedures to ensure the safety of equipment in theatres and we had concerns about the oversight of safety checks in theatres. Records were not stored securely on all wards and we had concerns relating to the safe management of medicines. We were not assured that incidents were always identified, reported and investigated in a timely way or that duty of candour requirements were consistently met. Nine staff expressed concerns around staffing. However, senior staff were taking action to address this and staffing levels had improved in most areas. There were improvements in relation to decontamination of cystoscopes and the consultant rota for gastric bleeds.
- We rated safety in maternity as inadequate. Mandatory and safeguarding training compliance rates did not meet the trust's target completion rate which posed a safety risk to women using the service. The design, maintenance and use of the facilities on the early pregnancy unit and the maternity facilities at Wisbech did not keep service users safe. There was a lack of a formalised process to ensure that consistent care was given to women with high-risk care pathways, such as twin pregnancies. The service did not have a positive incident reporting culture and midwifery staff were concerned that consultants within the service had downgraded the level of harm on incidents upon review.
- Services for end of life care went down from good to requires improvement for safety. The trust's individualised plan of care (IPOC) for patients receiving end of life care was rolled out to all wards. However, the process was not fully embedded and during our inspection there was no evidence of the IPOC in use. There were inconsistences in how medication for end of life care was prescribed and recorded. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Staffing levels for the specialist palliative care team (SPCT) was in line with national recommendations.
- Outpatient services were rated requires improvement for safety. Mandatory training compliance rates did not meet trust requirements with rates between 62% and 69% for key areas. Staff involved in providing care to children were not trained to safeguarding level three for children. There were concerns regarding the checking of resuscitation equipment in the paediatric clinic and poor monitoring of infection prevention and control. We were not assured that World Health Organisation five steps to safer surgery recommendations prior to minor procedures were consistently monitored. However, there was a positive culture around reporting and learning from incidents and the service had improved the storage of records and medicines.
- Diagnostic imaging services was rated requires improvement for safety. There was a potential risk of abuse to patients and staff as chaperones were not routinely offered or provided during intimate imaging procedures. Radiology staff did not meet the trust wide target for adults and children safeguarding training or mandatory training.

Summary of findings

Staff In the computerised tomography (CT) department referred to out of date protocols and radiology staff did not complete clinical room and equipment cleaning records appropriately. Staff across the radiology service did not follow National guidance in regard to 6-point patient identification check when patients attended for imaging procedures. Medicine security was not robust in the breast care unit where staff stored personal medicines along with stock medicines. There was limited evidence managers shared feedback and learning from incidents and complaints consistently among wider teams. However, staff recognised incidents and reported them appropriately and there had been no reported never events. Staff kept appropriate records of patients' care and treatment.

Are services effective?

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

- Urgent and emergency care had gone down from good to requires improvement for effective. A significant number of clinical guidelines were out of date for review. There was limited evidence of learning and action when national audit results were in the lower UK quartile. We were not provided with evidence that urgent and emergency services were following a trust-wide process to ensure that compliance with new or updated National Institute of Health and Care Excellence (NICE) guidance was regularly reviewed. Appraisal completion rates were below the trust target. Whilst there was positive multidisciplinary working amongst members of the emergency department team, this did not always extend to other colleagues and teams. However, staff were familiar with the Mental Capacity Act and could demonstrate how they would apply this in practice. The department had a full-time practice development nurse (PDN), who provided monthly clinical updates and monthly simulation scenarios for staff in the department. The department's unplanned re-attendance rate was consistently better than the England average between February 2017 and January 2018.
- Medical services had gone down from good to requires improvement in the effective domain. The service was performing worse than the national average for six of the seven standards relating to discharge, and in the2017 National Audit of Inpatient Falls; There were concerns around ensuring agency nursing staff and staff who had been moved between wards to cover gaps in rotas had the competencies and skills for the ward in which they were placed. Although there was a comprehensive local audit schedule, there was limited evidence that audit results were acted upon as a means of continuous quality improvement for the service. Weight and nutritional assessments, and fluid balance charts, were not always completed consistently and accurately. Staff knowledge of mental capacity assessments was poor. Mental capacity assessments were not being completed appropriately and consistently, and DNACPR records in patient notes were unclear.
- Surgical services went down from good to requires improvement in effective. Concerns related to staff understanding and implementation of the Mental Capacity Act and Deprivation of Liberty Safeguards. Patient care records showed omissions in relation to mental capacity assessment. Staff appraisal rates were below trust target and implementation of local clinical audit was variable. However, staff worked together to meet patients' needs and delivered care in line with national and local guidance.
- We rated the effectiveness of maternity as requires improvement. The service had a significant number of outdated guidelines which posed a risk that patient pathways and care were not being given in line with national guidance. The service conducted a very limited number of local audits and actions from these were not implemented in a timely fashion. Staff training rates were poor in respect of cardiotocography training, with just 14.28% of medical staff trained at the time of our inspection. Staff did not work effectively as a multidisciplinary team to deliver care to women.
- Services for end of life care went down from good to inadequate for effectiveness. The 'do not attempt cardio-pulmonary resuscitation' 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 do not attempt cardio pulmonary resuscitation (DNACPR) documentation. 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. The service did not routinely audit the effectiveness of care and treatment and use the findings to improve. Although we saw staff performing procedures linked to national guidance, we found out of date paper copies of guidance kept in departments which meant staff referring to them did not have the most recent versions. However, managers made sure staff were competent for their roles and staff worked together as a team to benefit patients. Staff accessed accurate and comprehensive information on patients' care and treatment and understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- We do not currently rate the effectiveness of diagnostic imaging services. The service held Imaging Services Accreditation, (ISAS) and provided care and treatment based on national guidance and carried out audit to monitor the effectiveness. Staff of different specialisms worked together as a team to benefit patients. Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. However, staff in the computerised tomography (CT) department referred to protocols which applied to a decommissioned piece of equipment. Four other protocols we reviewed were out of review period. The service did not meet the trust wide target for staff appraisal.

Are services caring?

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

- Urgent and emergency care remained good for caring. We observed many examples of caring interactions between staff and patients. Staff were observed to be supportive and respectful. The majority of patients provided positive feedback about the care provided by staff. We observed several occasions where timely emotional support was being provided to recently bereaved relatives. However, we also observed several occasions where this was not provided. The majority of patients felt that they had been treated with dignity and that their privacy had been respected. However, the privacy and dignity of patients was not always maintained due to the environment within the department.
- Medical services had gone down from good to requires improvement in the caring domain. Although staff displayed a kind, compassionate and dedicated approach to patients and relatives, they did not have the time or capacity to provide the level of support they would like. Due to these constraints, there was not always good communication from staff to ensure patients were fully involved in and understood decisions, and staff felt they could not provide the best level of emotional support to patients and relatives.
- Surgery services remained rated as good for caring. Staff delivered compassionate care and patients gave positive feedback about the service. Staff involved patients and those close to them in decisions about their care. We noted improvements in relation to privacy in the breast care unit.
- We rated maternity as good for caring. Women spoke positively about their experiences using the service and told us that staff were kind. Women and their relative's felt included in decisions surrounding their care. We observed that staff provided emotional support to women experiencing complications and were compassionate in their approach.
- 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.

Summary of findings

- Outpatient services were rated as good for caring. Staff provided compassionate care protecting patient's dignity. Feedback from patients was very positive and staff involved patients and those close to them in decisions about their care and treatment. Specialist nurses provided both support in clinic and by telephone with advice lines for patients to contact and helped provide emotional support to patients to minimise their distress.
- Diagnostic imaging services were rated as good for caring. Staff cared for patients with compassion and feedback from patients confirmed that staff treated them well and with kindness. Staff greeted patients by their name and introduced themselves. Staff protected patient dignity and enquired after patients' comfort during interventions. Staff involved patients and those close to them in decisions about their care and treatment and provided emotional support to patients when required.

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. There were a number of factors impacting on flow through the department, including the layout of the department, the allocation and movement of staff, areas within the department not always being used as intended, and delays in the assessment and treatment of patients with mental health conditions. Although admission avoidance provision was in place, including the ambulatory emergency care unit, the paediatric assessment unit and the rapid assessment team, these often had limited hours of availability, which therefore limited the number of admissions that could be avoided. In addition, the AEC had insufficient capacity to meet demand. Policies and protocols in place to manage escalation and crowding lacked clarity. However, the department had access to a rapid assessment team (RAT) and a patient flow coordinator, which worked to improve flow through the department.
- Medical services had gone down from good to requires improvement for responsive. Access and flow was not being effectively managed at the time of inspection, in part due to staffing and capacity issues and 'winter pressures', although access and flow within endoscopy was better. Medical outliers were a frequent issue due to beds not being available on the most appropriate ward. Referral to treatment time (RTT) for admitted pathways had declined from being better than the national average in January 2017 to being worse than the national average in December 2017. Discharge planning did not always take into account the particular needs of individual patients and staff raised concerns that there was a focus on quick discharges rather than ensuring all patient needs had been considered prior to discharge. Individual needs were not always met promptly due to call bells being unanswered for prolonged periods. The trust did not have an electronic flagging system for patients with dementia. Complaints were dealt with in 35 days which was longer than the 30 days stated in trust policy, and staff did not always receive feedback and learning from complaints.
- Surgery services went down from good to requires improvement for responsive. There were concerns related to the planning of services to meet patients' needs, particularly in relation to the location of the elective admissions unit. Access and flow was not always managed effectively within the service and in some specialities patients could not access the service in a timely way. Documentation of patients' individual needs was not always completed in a timely way. We were not assured that learning from complaints was shared with staff on all wards. However, referral to treatment times were better than the England average for five specialities and the average length of stay was lower than the England average. We saw examples of staff adapting their communication to meet patients' individual needs.
- Maternity services went down from requires improvement to inadequate for responsive. Vulnerable service users were not prioritised by the service. The services bereavement suite and arrangements for women who miscarried

Summary of findings

before 16 weeks were unsuitable. The service's waiting areas for antenatal clinics was unsuitable as it was shared with gynaecology patients experiencing fertility concerns. The trust did not have information regarding the service featured on its website and referrals for antenatal clinics were not tracked which led high-risk women to missing or experiencing delayed appointments.

- Services for end of life remained good for responsive. 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.
- Outpatients services were rated as requires improvement for responsive. The average waiting times of patients being referred for non-cancer treatment declined between June 2017 and March 2018 at 81% with non-admitted referral to treatment pathway rates lower than operational standard of 92% and the England average of 87%. This meant that patients were waiting longer for appointments after being referred by their GP. Patients with cancer did not always receive treatment within 62 days of referral with rates at 81.2% against an operational standard of 85% and the England average at 84.6%. The trust failed to collect data on late starting clinics or patient wait within the department despite acknowledging that this was a concern. Complaints were not investigated and closed within 30 days which was not in line with their complaints policy.
- Diagnostic imaging services were rated as requires improvement for responsive. Services did not meet the needs of local people as patients were unable to access diagnostic imaging services in a timely manner. The service was not meeting the six weeks referral to treatment target (RTT). The service did not meet the reporting turnaround time target of 90% of images within 24 hours. The service did not display patient information in any other language than English throughout the departments we visited and there was no evidence of sharing and learning from complaints. However, the service took account of patients' individual needs and staff knew how to access a wide range of services to improve patient experience. For example, interpreters for those patients whose first language was not English. The service investigated complaints and concerns within the time frame.

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. Leaders either had not identified or had not acted to address some of the concerns that we identified during our inspection. Action had not been taken to address some concerns identified during our previous inspection in 2015. Learning from external reviews was not effectively used to make improvements. There were not always robust arrangements for identifying, recording and managing risks or for ensuring that the information used to monitor, manage and report on quality and performance was accurate, valid, reliable, timely and relevant. However, there was a positive culture and leaders were perceived to be visible and supportive.
- Medical services went down from good to inadequate for the well-led domain. Staff felt there was poor support and communication from the trust senior team, and that their concerns were not listened to. This led to a poor culture and morale with staff feeling disengaged and under pressure. Due to the issues identified in relation to record keeping, staffing, mental capacity and outliers, we had concerns about the strength of governance processes in the service. Risk management was not effective. The risk register did not reflect all the risks we found on inspection, such as those around nutrition and hydration, mental capacity assessments, patient records, and agency staff induction procedures. There was no evidence that actions to address the main risks on the register, namely in relation to low nurse staffing, were having any meaningful effect. Although staff were highly committed to their work, there was a lack of systems in place for staff engagement and recognition. There was a lack of clear strategy to ensure the development, improvement and sustainability of the service; and management did not demonstrate effective strategic oversight.

Summary of findings

- Surgery services went down from good to requires improvement for well led. There was no vision and strategy in place for the service and there were concerns around governance processes relating to sharing of information, risk management and performance reporting. Staff gave variable feedback on the response of leaders to their concerns. However, most staff described a positive culture within the service and we saw examples of innovation in theatres.
- We rated maternity as inadequate for well led. We found that historic concerns with culture within the service had not been resolved. There was a breakdown in the relationship between consultants and midwives and between senior leaders within the service. The service did not have a strategic plan or effective structures, processes and systems of risk management in place. The service did not have oversight of their key risks and were not taking action in respect of poor mandatory training compliance rates for medical staff within the service. There was not a systematic programme of clinical and internal audit in the service to monitor quality.
- Services for end of life remained requires improvement for well led. The end of life care strategy was ratified in February 2018 and therefore had not been embedded fully. Implementation of the strategy and various initiatives such as the amber care bundle and the IPOC have been very slow due to lack of engagement from the medical team.
- Outpatient services were rated as requires improvement for well led. There was no outpatient vision or strategy. Local management did not ensure governance arrangements were effective in monitoring performance and there was a lack of local audit such as clinic waiting times and late starts. We were not assured that local risk and performance was monitored appropriately. There was a lack of recorded action plans to address concerns such as the declining referral to treatment times (RTT). It was unclear what actions for quality improvement had been put in place or acknowledgement of the risk to patients. There was inconsistent feedback from staff about support from the trust senior executive team, and a general concern staff voices were not heard.
- Diagnostic imaging services were rated as requires improvement for well led. We were not assured the service had robust structures, processes and systems in place to support the delivery of high quality person centred care especially in the radiology department. Consulting staff in the breast unit did not manage patient information securely leaving patient identifiable information visible on computer screens when they left the room. Radiology staff found it difficult to attend team meetings due to shift patterns and there was little evidence to show that staff who had not attended the team meetings had received the information. The service did not actively engage with patients to gain feedback on services and none of the staff we spoke with were aware of the trust's freedom to speak up guardian. However, the service had a vision for what it wanted to achieve around bringing reporting back inhouse and an informal strategy to turn it into action. Managers across the service promoted a positive culture that supported and valued staff and local leaders were visible, approachable and supportive to staff. The radiology department had a comprehensive audit programme to improve performance and safety and the service had effective systems for identifying risks, planning to eliminate them or reduce them.
- Overall the trust was rated as inadequate for well led. The delivery of high quality care was not assured by the leadership, governance or culture. Not all leaders had the appropriate range of skills, experience and knowledge of functioning at executive director level and executive and senior leadership development had not yet been formalised. At our last inspection report in 2015 we raised concerns in relation to midwifery staffing, clinical outcome data and leadership. We found that no significant changes or improvement had been made. The culture within the maternity service was dysfunctional. Professional working relationships between the midwifery staff and the consultant body were fragmented to such a point that the safety of patients within the service was impacted. Governance, risk management and board assurance was immature and insufficient. Organisational strategy, objectives and goals were not understood by leaders. There was little understanding of management of risks and issues. The trust was not self-regulating and the executive team were unaware of some significant concerns that we raised in urgent and emergency care, medicine and maternity services. The information used to monitor performance or make decisions

Summary of findings

was not always accurate and there was a lack of pace to undertake identified actions from issues raised by staff, CQC or external report recommendations. Where changes were made the impact on the quality and sustainability of care was not fully monitored. Engagement with staff, public and governors needed to improve. Learning and continuous improvement were not embedded across all services.

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, for The Queen Elizabeth Hospital King's Lynn 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.

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

Areas for improvement

We found areas for improvement including six breaches of legal requirements that the trust must put right. We found 38 things 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 six requirement notices to the trust and took two enforcement actions. 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 legal requirements at a trust-wide level and in all seven of the core services inspected.

We found significant concerns and risks to patients within the medicine service which were raised with the trust at the time of inspection. The trust responded immediately with appropriate actions taken and initiated an immediate action improvement plan.

During the core service inspections on 1 and 2 May we raised concerns with regard to paediatric staffing and competency within the urgent and emergency department. We issued a letter of intent, dated 11 May 2018, outlining possible urgent enforcement action under Section 31 of the Health and Social Care Act 2008 should the trust not undertake immediate actions to address our concerns. The trust responded appropriately and acted to address our concerns.

We also found significant concerns in relation to the maternity service which we raised with the trust executive directors on site. Following the core service inspection, we issued a warning notice under Section 29A of the Health and Social Care Act 2008 on 17 May 2018. This identified areas that the trust must improve and set a date for compliance as 31 July 2018. The trust initiated an immediate action improvement plan for maternity services.

Summary of findings

Following three serious incidents we issued, on 19 July 2018, an urgent notice of decision to impose conditions on the trusts registration as a service provider in respect of the maternity and midwifery service, under section 31 of the Health and Social Care Act, 2008. These conditions set out specific actions to enable the improvement of safety within the service.

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

Urgent and Emergency care

- The multi-disciplinary rapid assessment team worked in the emergency department to achieve admission avoidance or swift discharge for appropriate patients. The team had assessed an average of 390 patients a month from April 2017 to March 2018 and 58.4% of patients were discharged.

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 all seven of the core services inspected and the trust overall. The core services were urgent and emergency care, medical service, surgery, maternity, end of life care, outpatients and diagnostic imaging.

For the overall trust:

- The trust must ensure that mandatory training attendance, including training on infection prevention and control and safeguarding of vulnerable children and adults, improves to ensure that all staff are aware of current practices.
- The trust must ensure patient care records are accurate, complete and contemporaneous. This includes the accurate and consistent completion of weight and nutritional assessments and fluid balance charts.
- The trust must ensure mental capacity assessments are consistently and competently carried out where required. 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 there is an effective process for governance, quality improvement and risk management in all departments.
- The trust must ensure that processes for incident reporting, investigation, actions and learning are embedded across all services. Including effective monitoring of incident categorisation, grading, trend analysis and processes for staff to learn from incidents.
- The trust must ensure that serious incidents are identified, reported and investigated in a timely manner.

Summary of findings

- The trust must ensure that the duty of candour is carried out as soon as reasonably practicable, in line with national guidance.
- The trust must ensure that recommendations and learnings from regulators, external reviews and local audit are utilised to identify actions for improvement and that these are monitored and reviewed.
- The trust must ensure clear processes are in place for sharing learning from incidents, complaints and audits with staff.
- 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 that effective processes are in place, and monitored, to ensure clinical policies and guidelines are regularly reviewed and updated in line with national guidance.
- The trust must ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant.
- The trust must continue to 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 any escalation areas when in use.
- The trust must improve the culture, working relationships and engagement of consultant staff across all services.
- The trust must ensure that effective process for the management of staff grievances and complaints are in place, ensuring timely management in line with trust policy.
- The trust must ensure effective processes are in place to meet all the requirements of the fit and proper person's regulation.

Urgent and Emergency care

- The trust must ensure that resuscitation trolleys are checked in accordance with the trust policy and resuscitation council guidelines.
- The trust must review nursing and medical staffing numbers and plan staffing acuity accordingly.
- The trust must ensure that the environment within the emergency department is appropriate to provide safe care and treatment.
- The trust must ensure that serious incident action plans are comprehensive and that the completion of actions is monitored.
- The trust must review the arrangements for booking in patients and for the waiting area to ensure that patients at risk of deterioration are identified and escalated appropriately. Non-clinical staff responsible for booking in patients must have clear criteria for escalating patients to clinical staff.
- The trust must ensure that compliance with new or updated national guidance is regularly assessed and monitored, and improvements made where necessary.
- The trust must improve its performance times in relation to ambulance turnaround delays, four-hour target, patients waiting more than four hours from the decision to admit until being admitted and monthly median total time in A&E.

Medical care

- The trust must ensure the service has enough nursing staff, on all medical wards, to keep people safe from avoidable harm and to provide appropriate standards of care and treatment.

Summary of findings

- The trust must ensure staff have ready access to required equipment, including resuscitation equipment.
- The trust must ensure there are sufficient and appropriate induction procedures for agency staff and competency checks for both agency staff and substantive staff who are moved from other areas of the hospital.
- The trust must ensure there are processes in place to reduce the risk of medicines errors.
- The trust must ensure the risk register is reflective of all the risks in the service and includes relevant actions to mitigate risk.

Surgery

- The trust must ensure that staff follow infection prevention and control procedures in relation to hand hygiene, disposal of intravenous equipment and clothing in theatres.
- The trust must ensure that plans to improve arrangements for disposing of waste on SAU and Elm ward are implemented, to ensure compliance with infection prevention and control procedures.
- The trust must ensure that staff in theatres have clear guidance, and effective processes are implemented, in relation to the required safety checks for anaesthetic equipment and the malignant hyperthermia trolley.
- The trust must ensure that medicines are stored, prescribed and administered safely, in line with trust policy.
- The trust must ensure that patient care records are stored securely in all areas.
- The trust must review the location of the elective admissions unit to ensure that the needs of patients are met.
- The trust must ensure that the world health organisation (WHO) and five steps to safer surgery checklist is used consistently in theatres and that effective process is in place for quality audit of all five steps of the checklist.
- The trust must ensure there are clear governance processes in place, particularly in relation to the monitoring of safety checks in theatre, identification and management of risk and reporting of performance to the board.

Maternity

- The trust must monitor medical staff training rates, and improve appraisal rates to meet the trust target.
- The trust must improve cardiotocography training rates.
- The trust must ensure that the environment at Wisbech hospital and in the early pregnancy unit is appropriate to provide safe care and treatment.
- The trust must ensure that there are effective processes in place for quality improvement and risk management.
- The trust must ensure that effective arrangements are in place for vulnerable service users.
- The trust must ensure that service users with high risk care pathways receive consistent care planning and appropriate consultant review.
- The trust must ensure that clinical guidelines are regularly reviewed and contain up-to-date national guidance.
- The trust must ensure that the world health organisation (WHO) and five steps to safer surgery checklist is used consistently within obstetric theatres.
- The trust must improve its local audit programme and review national audit outcomes to improve patient outcomes.
- The trust must review the antenatal booking process to ensure that referrals are tracked.
- The trust must ensure that leaders within the service collaborate to improve the service and that culture and wellbeing of staff is improved.

Summary of findings

- The trust must ensure that women who have miscarried up to 16 weeks are cared for in a suitable environment.
- The trust must ensure that resuscitation trolleys are checked daily and that all medicines stored on resuscitation trolleys are in date.

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.

Outpatients

- The trust must ensure resuscitation equipment in the paediatric clinic is checked daily.
- The trust must ensure infection prevention and control audits are completed regularly and action taken to address concerns including cleaning of toys in waiting areas.

Diagnostic imaging

- The trust must ensure staff lock computer screens to protect patient information when leaving them unattended in the breast care unit.
- The trust must provide all patients with the option of a chaperone when undergoing diagnostic imaging in the cardio respiratory department.

Action the trust SHOULD take to improve

For the overall trust:

- The trust should ensure that effective processes are in place to promote and protect the health and wellbeing of all staff.

Urgent and Emergency care

- The trust should review the layout of the emergency department to ensure that it supports flow and meets the needs of local people.
- The trust should ensure that staff receive yearly appraisals.
- The trust should review the hours that the ambulatory emergency care unit, the paediatric assessment unit and the rapid assessment team are available to maximise admission avoidance.
- The trust should ensure that internal professional standards are created and monitored.
- The trust should review the policies and protocols in place to manage escalation and crowding.
- The trust should review the service provided for patients with mental health conditions to ensure that they receive timely assessment and treatment.
- The trust should ensure that patients, relatives and carers receive timely emotional support.
- The trust should ensure the service improves its local audit programme, including audits recommended in national guidance.
- The trust should review its communication aids available to assist staff to communicate with patients living with a sensory loss, such as hearing loss.

Summary of findings

- The trust should ensure that regular and minuted mortality and morbidity meetings take place for urgent and emergency services.
- The trust should ensure that plans in relation to the development of a strategy for the urgent and emergency service are implemented.

Medical care

- The trust should ensure there are systems in place to ensure the consistent and effective sharing of feedback and learning from complaints and incidents
- The trust should ensure there are systems in place to reduce and manage the high number of medical outliers.
- The trust should ensure call bells are answered promptly to respond to patient risk and need.
- The trust should ensure complaints are managed and responded to in a timely manner and in line with trust policy.
- The trust should ensure there are appropriate systems to ensure staff feel supported, engaged and listened to.
- The trust should ensure there is improved communication and multidisciplinary working with external services.

Surgery

- The trust should continue to implement plans to maintain sufficient nursing staff to meet the needs of patients.
- The trust should ensure that regular and minuted mortality and morbidity meetings take place for surgery services.
- The trust should ensure all staff receive an annual appraisal, in line with trust policy.
- The trust should ensure strategies to manage access to the service and patient flow through the service are embedded.
- The trust should ensure there are clear processes in place for sharing information with ward staff.
- The trust should ensure that plans in relation to development of a vision and strategy for the surgery service are implemented.
- The trust should ensure that information relating to the individual needs of patients is collected in a timely way.
- The trust should ensure all staff have access to relevant information management systems, to meet patients' needs.
- The trust should review the implementation of the local clinical audit programme for surgery services.

End of life care

- The trust should ensure morbidity and mortality meeting need to have a focus on the end of life care journey and how to improve end of life care.

Outpatients

- The trust should ensure that patients commence treatment for cancer within 62 days in line with national guidance.
- The trust should ensure that there is an effective process for quality improvement and risk management.
- The trust should ensure the service improves its local audit programme and review national audit outcomes to improve patient outcomes.
- The trust should ensure that the service improves the time taken to investigate complaints in line with its complaints policy.

Diagnostic imaging

Summary of findings

- The trust should ensure the secure storage, prescription and administration of medicines. This includes ensuring that appropriate patient group directives (PGD) are in place for the safe administration of medicines, including the safe administration of saline.
- The trust should ensure that resuscitation equipment in the breast care unit is easily accessible to all staff.
- The trust should ensure effective processes are established for the cleaning of clinical rooms and equipment in the radiology department.
- The trust should ensure all staff receive an annual appraisal, in line with trust policy.
- The trust should ensure effective processes are in place for the timely completion of diagnostic reports.
- The trust should review processes to ensure that patients are able to access diagnostic imaging services in a timely manner.

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 as inadequate because:

- At the time of inspection not all leaders had the appropriate range of skills, experience and knowledge to function confidently at executive director level. Three of the seven directors were in their first board level role. Formal development plans for the executive team were not in place.
- Leadership development opportunities, including opportunities for staff below team manager level were not widely available. Formal structured plans for senior leadership and development were in their infancy. This included triumvirate divisional leads and clinical business unit leaders.
- Arrangements in place to ensure that directors were fit to carry out their responsibility in accordance with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were not effectively undertaken or monitored.
- There was a lack of clarity around the vision and strategy for the trust. Staff knowledge was limited, leaders did not fully understand how their role contributed to achieving the strategy. The strategy was yet to be underpinned by detailed, realistic objectives and progress against delivery of the strategy was in its infancy.
- Staff satisfaction was mixed. Staff did not always feel respected, supported or valued. Handling of concerns and poor performance were not addressed in a timely or consistent manner and staff awareness of the Freedom to Speak up Guardian was inconsistent.
- The culture within the maternity service was significantly poor. Professional working relationships between the midwifery staff and the consultant body were fragmented to such a point that the safety of patients within the service was impacted.
- We found that there had been a lack of diligence to ensure that ongoing grievances within the maternity service were concluded in a timely manner. Staff complaints, poor performance and behaviours were not monitored effectively. There had been a lack of recognition and provision of pastoral care.

Summary of findings

- Structures, systems and processes for governance were not embedded or effective. There lacked consistency in the framework and structure of ward/ service team, division and senior trust meetings.
- There was a lack of shared learning and implementations of actions across services and divisions. When learnings were identified from several routes such as incidents, FTSU, whistleblowing, staff verbalisation there was a lack of action and follow through by the senior leaders within the organisation and lack of oversight by the board.
- Compliance with the 30-day target for completing a complaint was not consistently achieved. Of the 10 complaints reviewed this was only achieved in two cases (20%).
- Risk assessment and quality assurance process were not effective and challenge was not rigorous. We were not assured that the board had sight of the most significant risks or that mitigating actions were clear.
- Clinical and internal local audits were not sufficient to provide assurance. There was a lack of evidence that teams had acted on results, or action plans had progressed to bring risks under control and improve services.
- There was a tendency to rely on reassurance rather than evidence to provide assurance to the board. The chief executive officer, medical director and chief nurse all acknowledged a lack of pace to implement change.
- The process for reviewing and investigating deaths to meet national guidelines was not always working effectively. Progress towards this had been interrupted by the new governance structure and information flow between clinical business units, divisions and board were yet to be fully established.
- At the end of March 2018, the trust remained in a financially unsustainable position. There was no defined financial strategy. There was a potential risk of reliance on system wide solutions rather than the provision of clear internal plans to achieve financial stability.

However:

- The executive team were supportive of each other. The team consisted of individuals with diverse backgrounds and initial steps to working collectively and cohesively had been taken.
- There was an established process for the appointment of board members with evidence of elements of succession planning taking place for recent appointments of non-executive directors and consideration of this with the recruitment of executive director vacancy at the time of inspection.
- There was a structured approach to engaging with people who use the services and those close to them and their representatives.
- The trust was working alongside stakeholders, system partners, NHS England and NHS Improvement to improve patient flow through the hospital. Phased implementation of the West Norfolk Discharge to Assess project with West Norfolk clinical commissioning group had started

Use of resources

Please see the separate use of resources report for details of the assessment and the combined rating.

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 🡇 Aug 2018	Requires improvement 🡇 Aug 2018	Good ➔🡐 Aug 2018	Requires improvement ➔🡐 Aug 2018	Inadequate 🡇 Aug 2018	Inadequate 🡇 Aug 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 The Queen Elizabeth Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate ↓ Aug 2018	Requires improvement ↓ Aug 2018	Good → ← Aug 2018	Requires improvement ↓ Aug 2018	Inadequate ↓↓ Aug 2018	Inadequate ↓↓ Aug 2018
Medical care (including older people's care)	Inadequate ↓ Aug 2018	Requires improvement ↓ Aug 2018	Requires improvement ↓ Aug 2018	Requires improvement ↓ Aug 2018	Inadequate ↓↓ Aug 2018	Inadequate ↓↓ Aug 2018
Surgery	Requires improvement ↓ Aug 2018	Requires improvement ↓ Aug 2018	Good → ← Aug 2018	Requires improvement ↓ Aug 2018	Requires improvement ↓ Aug 2018	Requires improvement ↓ Aug 2018
Critical care	Good Jul 2015	Good Jul 2015	Good Jul 2015	Good Jul 2015	Good Jul 2015	Good Jul 2015
Maternity	Inadequate Aug 2018	Requires improvement Aug 2018	Good Aug 2018	Inadequate Aug 2018	Inadequate Aug 2018	Inadequate Aug 2018
Services for children and young people	Good Jul 2015	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2015
End of life care	Requires improvement ↓ Aug 2018	Inadequate ↓↓ Aug 2018	Good → ← Aug 2018	Good ↑ Aug 2018	Requires improvement → ← Aug 2018	Requires improvement → ← Aug 2018
Outpatients	Requires improvement Aug 2018	Not rated	Good Aug 2018	Requires improvement Aug 2018	Requires improvement Aug 2018	Requires improvement Aug 2018
Diagnostic imaging	Requires improvement Aug 2018	Not rated	Good Aug 2018	Requires improvement Aug 2018	Requires improvement Aug 2018	Requires improvement Aug 2018
Overall*	Inadequate ↓ Aug 2018	Requires improvement ↓ Aug 2018	Good → ← Aug 2018	Requires improvement → ← Aug 2018	Inadequate ↓ Aug 2018	Inadequate ↓ Aug 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.

Care Quality Commission

The Queen Elizabeth Hospital King's Lynn

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Key facts and figures

The Queen Elizabeth Hospital King's Lynn is an established 488 bed general hospital on the outskirts of King's Lynn, Norfolk. It provides healthcare services to West and North Norfolk. The population of this area is approximately 331,000 people. The population profile includes a high proportion of older residents; however, new housing developments in recent years have seen large population growth of principally young families.

The trust provides a comprehensive range of specialist, acute, obstetrics and community-based services. The trust works with neighbouring hospitals for the provision of tertiary services and is part of regional partnership and network models of care, such as the trauma network.

Between March 2017 and February 2018 there were:

•78,325 inpatient admissions

•324,655 outpatient attendances:

•64,783 accident and emergency attendances

As of January 2018, the trust employed 2803.2 whole time equivalent (WTE) staff out of an establishment of 3110.7 WTE, meaning the overall vacancy rate at the trust was 9.8%.

During this inspection we spoke with 289 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 61 patients, relatives and carers and reviewed 109 sets of patient records.

Summary of findings Acute Services

Inadequate ● ↓

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

Urgent and Emergency care

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

Summary of findings

- The service did not always have systems in place to ensure that staff were able to identify and respond appropriately to changing risks to people who used services.
- The design and use of facilities and premises in the emergency department did not always keep people safe.
- The numbers and skill mix of nursing and medical staff were not always suitable for the needs of the emergency department.
- Learning from serious incidents was not always robust.
- The trust target for mandatory training completion had not been met for any of the 10 mandatory training modules and appraisal completion rates were below the trust target.
- A significant number of clinical guidelines were out of date for review.
- Performance in national audits was mixed and there was limited evidence of learning and action when national audit results were in the lower UK quartile.
- We were not provided with evidence that urgent and emergency services were following a trust-wide process to ensure that compliance with new or updated National Institute of Health and Care Excellence (NICE) guidance was regularly reviewed.
- Access and flow through the department was being impacted by a range of factors, including the layout of the department, areas within department that were not being used as intended, the allocation and movement of staff, and delays in the assessment and treatment of patients with mental health concerns.
- Policies and protocols in place to manage escalation and crowding lacked clarity. No review or debrief had taken place by the time of our inspection in May 2018, despite the frequent and extended use of the protocol during the winter of 2017/2018.
- The processes that were in place to give leaders an oversight of performance were not always being utilised effectively to drive improvement.
- Leaders either had not identified or had not taken action to address some of the concerns that we identified during our inspection. Action had not been taken to address some concerns identified during our previous inspection in 2015. Learning from external reviews was not effectively used to make improvements.
- There were not always robust arrangements for identifying, recording and managing risks or for ensuring that the information used to monitor, manage and report on quality and performance was accurate, valid, reliable, timely and relevant.

However,

- Medicines storage and compliance with hand hygiene policies had improved since our last inspection.
- Staff were familiar with the Mental Capacity Act and could demonstrate how they would apply this in practice.
- The department had a full-time practice development nurse (PDN), who provided monthly clinical updates and monthly simulation scenarios for staff in the department.
- We observed many examples of caring interactions between staff and patients during our inspection. Staff were observed to be supportive and respectful. The majority of patients provided positive feedback about the care provided by staff.
- The department had access to a rapid assessment team (RAT) and a patient flow coordinator, which worked to improve flow through the department.

Summary of findings

- Staff were knowledgeable about how to respond if a patient complained and the complaints we reviewed had been dealt with appropriately.
- There was a positive culture throughout the urgent and emergency service, and staff said that leaders were visible and supportive.

Medical care

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

- The service did not have enough nursing staff at all times to keep people safe from avoidable harm and to provide the appropriate care and treatment. This was a breach of the Health and Social Care Act 2008 regulated activities regulations 2014 regulation 18: Staffing.
- There had been a number of medicines incidents between October 2017 and April 2018, including some that we witnessed during inspection, which we raised with leads at the time.
- There had been instances where staff had not been able to assess and respond to patient risk in an appropriate and timely way, due to staffing and capacity pressures.
- National early warning scores (NEWS) were not being completed fully and consistently which posed a risk to patient safety.
- Patient medical and nursing records were poor in their completion and clarity.
- Feedback and learning from incidents were not consistently shared among wider teams.
- Weight and nutritional assessments were not always completed consistently and accurately and we were concerned that capacity and staffing constraints posed a risk to the effective nutrition and hydration of all patients.
- There were concerns around ensuring agency nursing staff, and staff who had been moved to a different ward to cover gaps in rotas, had the competencies and skills for the ward in which they were placed. This was a concern particularly because there were occasions on Leverington and Terrington wards where they were staffed only by bank and agency nurses.
- Staff felt there were communication issues with external services including social care services and the community.
- Staff awareness of the Mental Capacity Act (MCA) was limited. Mental capacity assessments were not completed appropriately or reviewed in a timely manner.
- Call bells sometimes went unanswered for prolonged periods, especially at night, due to staffing and capacity constraints
- The trust did not have an electronic flagging system for patients with dementia.
- There was an issue with medical outliers due to capacity and flow through the hospital, meaning medical patients were not always treated on the ward most suited to their condition and needs.
- We had concerns that there was a focus on discharging patients as quickly as possible to free up beds, with a lack of focus on ensuring the patient's holistic needs were met prior to discharge. This was supported by feedback from staff and patients who felt that discharges were on occasion unsafe or too early.
- There was variable feedback about the support from the trust senior team, including concerns that they did not do enough to ensure staff voices were heard.
- Nursing leads told us they struggled to fulfil their managerial and support responsibilities due to low staffing which meant they worked clinically and were included in the staffing numbers most of the time.

Summary of findings

- Morale was low among nursing staff in many medical wards and there was a poor culture due to staff not feeling their concerns were listened to or acted upon.
- Not all of the areas of risk that we saw on inspection had been identified on the risk register, such as those around mental capacity assessments, patient records, and agency staff induction procedures.
- Governance and risk management processes were not sufficiently robust to ensure there was effective oversight, monitoring and mitigation of all the areas of concern and risk.
- Although staff were highly committed to their work, there was a lack of systems in place to reward staff, encourage their development, and continuously engage them.

However, we also found the following areas of good practice:

- The endoscopy service had achieved Joint Advisory Group on Endoscopy (JAG) accreditation in September 2017.
- Patients' pain was managed well and staff had good access to the trust pain control team.
- The service had improved in the 2017 National Diabetes Inpatient Audit compared to the 2016 audit.
- Staff were compassionate and displayed a patient-centred approach and patients reported that staff were kind and caring, although staff did not have the time and capacity to provide the level of care and support they would like to
- There were initiatives to meet the needs of patients living with dementia, such as longer visiting hours, encouraging families to bring in personal items or photos for patients, and a therapy dog.
- The service was responsive to the needs of patients with learning disabilities. There was an electronic flagging system and a learning disability liaison team to provide support, and a 'my hospital passport' system in place for patients with learning disabilities, which had been developed by the mental health team and the learning disability liaison service.
- The medical assessment unit used a band four triage nurse to support discharge and help flow through the service.

Surgery

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

- Compliance with mandatory training was below the trust target. The trust target was 90% for medicine management training and 95% for all other modules. The trust target was not met for any of the 10 mandatory training modules for medical staff and was only met for one of the nine modules for nursing staff.
- Compliance with safeguarding training for medical staff was below the trust target. Medical staff did not meet the trust target of 95% for any of the three safeguarding training modules.
- We had concerns about how staff controlled infection risk. Staff compliance with infection prevention training was 68% for medical staff and 77% for nursing staff, both of which were below the trust target. Results of hand hygiene audits showed variable compliance and some staff did not follow infection prevention and control procedures.
- The arrangements for disposing of waste on SAU and Elm ward presented a potential risk in terms of infection control. The two ward areas shared a single sluice room, which meant there was a risk of spreading infection between the two wards.
- There were some gaps in procedures to ensure the safety of equipment. One anaesthetic machine and one malignant hyperthermia trolley (which contains equipment and medicine to counteract a severe reaction to anaesthetic) did not have clear checklists for staff to follow in relation to safety checks. We raised this with staff at the time of inspection and they told us they would address this.

Summary of findings

- Staff did not store patient care records securely in all areas, which meant there was a risk of breaches to patient confidentiality.
- Staff did not always store, prescribe and administer medicines well. The process for monitoring medicines refrigerator temperatures was inconsistent and there were occasions where medicines were not monitored, stored or prescribed appropriately.
- Not all aspects of the World Health Organisation and five steps to safer surgery (WHO checklist) were effectively implemented or audited. We were not assured that senior staff had responded to never events in a timely way to monitor and improve the quality of these safety checks. Observational audits of the WHO checklist had only recently been introduced and were limited to a small sample size. Staff in theatres told us the debrief stage of the WHO checklist was not consistently completed or recorded.
- Serious incidents were not always identified, reported and investigated in a timely manner. Opportunities for learning from incidents were not maximised in all areas.
- We were not assured that staff attended regular morbidity and mortality meetings in order to discuss and learn from adverse outcomes.
- Data from the patient safety thermometer did not demonstrate sustained improvement in safety outcomes and we were not assured that learning and actions following incidents were shared effectively in all areas.
- When things went wrong, staff did not always carry out the duty of candour (a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Nine staff expressed concerns about nursing staffing. They told us that staffing shortages affected their ability to provide one to one care and rehabilitation. Staff rotas on Elm ward and Gayton ward showed a high number of unfilled shifts and data provided by the trust showed high vacancy rates in some areas. Senior staff were aware of the areas affected by staffing shortages and information provided by the trust after inspection showed improvements in nursing staffing levels.
- There was a high level of bank and agency staff use within the service. Staff told us this could affect the service because agency staff did not have access to the electronic system for arranging patients' discharge and had variable skill sets.
- Staff knowledge relating to the Mental Capacity Act 2005 was poor and patient care records showed omissions in relation to mental capacity assessment. This meant there was a risk that patients who lacked the capacity to consent to treatment may not have been supported appropriately to make decisions and that decisions may not have reflected the patients' best interests.
- Records provided by the trust did not assure us that staff had received training on Deprivation of Liberty Safeguards (DoLS) legislation and staff we spoke with lacked knowledge in relation to this legislation. This meant there was a risk staff would not recognise when a vulnerable patient was being deprived of their liberty.
- We were not assured that procedures to apply for and receive authorisation for DoLS were consistently followed. This meant there was a risk that patients could be deprived of their liberty without the appropriate processes in place to safeguard their rights.
- The local clinical audit programme was not effectively implemented on all wards and we were not assured that learning from audits was shared with all staff. This meant there was not a consistent approach to improving the quality of the service.

Summary of findings

- Appraisal rates for medical and nursing staff within the service were 82% and 83% respectively, both of which were below the trust target of 90%.
- The planning of services did not always meet the needs of local people. The location of the elective admissions unit was not suitable and had negatively impacted the experience of some patients.
- Information displays showed limited evidence of changes implemented in response to patient feedback.
- In two specialities, patients could not access services in a timely way. Referral to treatment times for orthopaedic and ENT surgery were worse than the England average.
- Access and flow was not always managed effectively within the service. There was a high number of medical outliers on surgery wards and the ambulatory area on the surgical assessment unit was not open due to staffing shortages. Initiatives to improve patient flow were not embedded in the service.
- Information relating to the individual needs of patients living with dementia was not always completed in a timely way.
- We were not assured that learning from complaints was shared with staff on all wards.
- Governance processes were not embedded on all wards and we were not assured there was a systematic approach to continually improving the quality of services. For example, implementation of local clinical audit varied across wards and we were not assured that there were effective processes for sharing information with staff on all wards.
- We were not assured that systems for identifying and managing risks were always effective. Some concerns we identified during inspection, for example those relating to mental capacity assessments, duty of candour and mandatory training, had not been identified as risks and we were not assured that the risk relating to disposal of waste on SAU and Elm ward was being adequately managed. The risk register did not identify clear ownership of each risk.
- We found some gaps in leaders' oversight of quality and reporting of performance to the board.
- The leadership structure within the service was not fully embedded and staff gave variable feedback about the response from leaders to their concerns.
- Staff knowledge of the trust's vision and values was variable and there was no service specific vision and strategy in place at the time of inspection.
- Information management systems did not always provide staff with the information needed to meet patients' needs. Agency staff did not have access to IT systems and medical staff told us systems for making referrals and requesting investigations were confusing.

However,

- 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 understood how to raise a safeguarding concern. Nursing staff met the 95% trust target for safeguarding training.
- Staff we spoke with knew how to recognise and report incidents.
- Staff collected safety information and shared it with staff, patients and visitors.
- Staff had addressed concerns raised at our previous inspection around the decontamination of flexible cystoscopes.
- Staff had addressed concerns raised at our previous inspection around the consultant rota for gastric bleeds.

Summary of findings

- Staff were supported to attend additional training courses to improve role-specific competencies.
- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to meet patients' needs.
- The service monitored the effectiveness of care and treatment through participation in national audit.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness and staff had addressed concerns from our last inspection around privacy and dignity in the breast care unit.
- 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.
- Referral to treatment times for oral surgery, plastic surgery, urology, ophthalmology and general surgery were better than the England average. The percentage of cancelled operations at the trust where the patient was not treated in 28 days was generally lower than the England average.
- The average length of stay for elective and emergency patients was lower than the England average.
- Staff adapted their communication to meet patients' individual needs and could access specialist staff to support patients with complex needs.
- The service treated concerns and complaints seriously and investigated them. Staff could give examples of actions taken in response to complaints.
- Most staff described a positive culture that supported and valued staff.
- The trust had made significant investment in theatres, to support the training of doctors and ensure theatres were appropriately equipped for laser surgery.

Maternity

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.

We rated the service as inadequate because:

- The service did not meet the trust training targets for mandatory training. The service had low levels of compliance with resuscitation training, compliance was 65% for medical staff and 73% of midwifery staff. Infection prevention and control training compliance was 43% for medical staff and 66% for midwifery staff. This posed a safety risk that a significant proportion medical and midwifery staff were not trained to deal with resuscitation and may lack an awareness of infection prevention and control.
- The service did not meet trust safeguarding training targets. The trusts compliance for children's safeguarding Level 3 was 54% which did not comply with national guidance. This meant that there was a risk that midwives did not have adequate safeguarding training to deal with safeguarding issues with children despite contributing to their care.

Summary of findings

- We were not assured that the service ensured staff were competent for their roles. The medical appraisal rate was 50% and the service did not keep records of medical staff's training. The service had poor training rates in relation to cardiotocography (CTG) training, compliance rate for medical staff was 14.28% out of a possible 21 staff and for midwifery staff was 61.68%. The lack of CTG training compliance for medical staff posed a real and substantial risk to women and their babies.
- The General Medical Council (GMC) national training survey showed that for obstetrics and gynaecology the service had below the national average results for educational governance, curriculum coverage, adequate experience, induction, supportive environment, teamwork, reporting systems and clinical supervision. This suggested that junior medical staff within the service were not having their training needs adequately supported to ensure effective and quality care was being delivered to women using the service.
- The service did not currently participate in multidisciplinary scenario based simulations. This meant that the service had not practised its procedures for major medical and safety related events such as child abduction.
- Staff told us that there was a lack of engagement from medical staff with the PROMPT training or GROW training despite being assigned to run training sessions. This affected the services ability to deliver effective training to staff.
- The maternity facilities at Wisbech and the early pregnancy assessment unit on Appleton ward were not fit for purpose and risked the safety of service users. This included a potential safety risk to women should they deteriorate as space was limited. This had not been appropriately risk assessed at the time of our inspection.
- Systems were not in place to ensure timely access for vulnerable women. There was a lack of ownership for care planning for high-risk service-users by consultants and booking processes for consultant-led antenatal clinics were ineffective. The service ran a limited number of vulnerable women clinics and demand outstripped resource in the service.
- Women's individualised care records, were not always written and managed in a way that kept women safe. There was limited information written in women's records regarding care planning and we identified instances where antenatal appointments had not been recorded in women's electronic records.
- We were not assured that there was a positive incident reporting culture within the service and that incidents were being investigated appropriately. We found examples of incidents that had been graded as no harm when women had suffered short-term harm or the incident resulted in further treatment. This reduced the opportunity of shared learning and meant potential re-occurrence.
- There was a lack of quality improvement within the service. We were not assured that the service utilised data regarding patient outcomes to improve services. We found that there had been no local audit reports within the service since May 2017.
- We found that the leaders, both midwifery and clinician, could not work together and did not demonstrate integrity on an ongoing basis. We were not assured that leaders understood the challenges to quality and sustainability of high quality patient care.
- We found that there were not comprehensive assurance systems of risk within the service. We were concerned that risks were not escalated appropriately and that the structures and processes for risk management did not allow risk actions to move progressively. The service's lack of oversight of risk meant that areas within the service were potentially unsafe.
- The service had a poor culture. Issues with culture and consultant engagement within the service had not been resolved despite being raised on our June 2015 inspection.

However:

Summary of findings

- We observed that midwives provided compassionate care to women using the service.
- The service had improved women's choice since our June 2015 inspection by now offering a full choice between home birth services, midwifery led services in the waterlily midwifery led birthing unit and the obstetric led central delivery suite.

End of life care

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

- Patient medical and nursing records were not completed or managed in a way that kept patients safe.
- The trust's individualised plan of care (IPOC) for patients receiving end of life care was in the process of being rolled out to all wards. However, the process was not fully embedded and during our inspection there was no evidence of the IPOC in use.
- The trust target for mandatory training completion had not been met for nine of mandatory training modules. Overall compliance was 79.7%
- Palliative consultant staffing was not in line with guidance from The Association of Palliative Medicine for Great Britain and Ireland, and the National Council for Palliative Care, which recommend there should be a minimum of one consultant to 250 beds. The trust has 483 inpatient beds, which would require at least 2 WTE consultants. The trust employed one WTE speciality doctor for palliative care and was recruiting for a palliative consultant.
- There were inconsistences in how medication was prescribed and recorded. In two of the six prescription records we reviewed, one record had three different as required' antiemetics (anti-sickness medicines) prescribed with no clear indication of which ones to use when. In another prescription record two different types of painkillers were prescribed with no directions on the prescription chart for when each drug should be used.
- The trust's 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms 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.
- There was limited evidence that audit results were acted upon as a means of continuous quality improvement for the service.
- Implementation of the end of life care strategy and various initiatives such as the amber care bundle and the IPOC have been very slow due to lack of engagement from the medical team.

However:

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.
- 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.
- There was a seven-day specialist palliative service which was an improvement from the last inspection.
- 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.

Summary of findings

- 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. This was an improvement from the last inspection.

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:

- Patients with cancer were not always seen in line with national guidance timeframes. The trust performed worse than the England average for people commencing treatment for cancer within 62 days.
- Average waiting times of patients being referred for treatment declined between June 2017 and March 2018. Non-admitted referral to treatment (RTT) pathway rates were 81% against the operational standard of 92% and the England average of 87%. This meant that patients were waiting longer for appointments after being referred by their GP.
- The equipment was not always fit for purpose, for instance the Roxburgh Unit paediatric outpatient resuscitation grab bag contained two paediatric airways which were out of date in November 2017.
- The environment did not always meet the needs of the service. The dental laboratory was generally in need of refurbishment, and the ophthalmology clinic signage was poor. This had not improved since the previous inspection.
- We found inconsistencies with IPC measures such as non-wipeable furniture, toys in children's area and lack of records to ensure monitoring was taking place.
- Staff mandatory training was inconsistent, with nursing staff training rates between 62% and 69% for key areas such as; infection prevention, equality and diversity, fire safety and resuscitation. Main outpatient staff were not trained to level three safeguarding for children despite being involved in their care. This was in the process of being addressed.
- The outcomes of peoples care and treatment were not monitored regularly or robustly. The service did not routinely audit the effectiveness of care and treatment and use the findings to make improvements
- The service showed poor commitment to improving the quality of its services and safeguarding high standards as there was little or no audit programme for outpatients to improve performance and safety.
- The outpatient service did not always ensure that the most up to date national guidance was used with out of date paper copies kept in departments. This meant staff referring to them did not refer to the most recent versions.
- The trust did not collect data on late starting clinics or length of patient waits within the department despite acknowledging that this was a concern. This meant that they could not benchmark and demonstrate any improvement or worsening picture
- The average time taken to investigate and close complaints was 46 days which was not in line with their complaints policy.
- Car parking facilities did not always meet demand, with patients reporting that they often had difficulty parking for clinic appointments.
- We were not assured that local governance arrangements were effective. There was a lack of action plans to address concerns such as RTT decline, and no evidence provided of quality improvement and risk management.
- Local engagement within teams was good but the trust did not engage well with patients, staff, the public and local organisations to plan and manage appropriate services. There was inconsistent feedback from staff about support from the trust senior executive team, and a general concern staff voices were not heard.

Summary of findings

- There was poor visibility of executive level leadership with staff feeling disaffected by trust decisions.
- The trust had a vision for what it wanted to achieve but there was no vision or strategy for the outpatients' department developed with involvement from staff, patients, or key groups representing the local community.

However, we also found the following areas of good practice:

- The service managed patient safety incidents well. Managers investigated incidents and shared lessons learned with their teams. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service managed medicines prescription and storage well. This was an improvement since the last inspection.
- The service managed and stored patient records to protect patient confidentiality. Records were clear, up-to-date and available to all staff providing care. This was an improvement since the last inspection.
- Staff received safeguarding training and knew how to recognise and protect patients from abuse.
- Staffing levels were sufficient for the service needs with the right qualifications, skills, training and experience to provide the right care and treatment.
- Staff worked together as a team to benefit patients, and 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 and the Friends and Family Test results were positive with an overall recommendation of 96.5% between March 2017 and February 2018.
- 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 and specialist nurses provided support in clinics and by telephone in some areas.
- The service took account of patients' individual needs, providing specialist facilities in some areas and arrangements for those with communication difficulties.
- The service performed better than the England average for people being seen within two weeks of an urgent GP referral, between January 2017 to May 2018. The arrangements to admit, treat and discharge cancer patients were mostly in line with good practice.
- The outpatient service local managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

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:

- Staff in the cardiorespiratory department and the ultrasound department did not routinely offer chaperones or observe consultants during intimate patient imaging procedures.
- Consulting staff in the breast unit did not secure patient identifiable information on computer screens when they left the room. This was a breach of the Health and Social Care Act 2008 regulated activities regulations 2014 regulation 17: Governance.
- Radiology staff did not meet the trust wide target of 95% compliance for adults and children safeguarding training. Radiology medical staff achieved 64% and allied health professional staff achieved 66%.

Summary of findings

- Breast care staff achieved 75% compliance for children safeguarding training, this did not meet the trust wide target of 95%.
- Radiology medical staff did not meet the trust wide target for mandatory training compliance (95%) in nine out of ten modules Including resuscitation training where only 50% of staff had completed the training.
- Allied health professional staff did not meet the trust wide target for mandatory training compliance (95%) in six out of ten modules including resuscitation training where only 67% of staff had received the training.
- Allied health professional staff did not meet the trust wide target for appraisal (90%) with only 61% of staff receiving an appraisal.
- Staff In the computerised tomography (CT) department referred to out of date protocols and protocols which applied to a decommissioned piece of equipment.
- Staff members in the radiology department did not consistently complete cleaning records. This meant that cleaning procedures were not followed appropriately and there was a potential infection prevention control risk.
- Waiting times from referral to treatment were worse than the England average and the trust was reporting 47% of images within 24 hours. This was not meeting the reporting turnaround time target of 90% of images within 24 hours.
- We had some concerns around the secure storage, prescription and administration of medicines. In the breast care unit staff stored personal medicines in the secure medicines cupboard. Staff in the magnetic resonance imaging unit (MRI) administered saline without the presence of a patient group directive (PGD) for its administration.
- There was no evidence of sharing the learning from complaints with staff.
- We were not assured the service had robust structures, processes and systems in place to support the delivery of high quality person centred care especially in the radiology department.

However,

- The service managed patient safety incidents well. There had been no reported never events in the service between April 2017 and March 2018.
- Staff could access appropriate records of patients' care at the point of providing care and treatment. Staff provided care based on national guidance and monitored the effectiveness through audit.
- Staff of different specialisms worked together as a team to benefit patients and always had access to up-to-date, accurate and comprehensive information on patients' care and treatment.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005 and involved patients and those close to them in decisions about their care and treatment where appropriate.
- Staff cared for patients with compassion and kindness and provided emotional support to patients when required. Staff greeted patients by their name, asked patients what they prefer to be called, enquired after their comfort and protected their dignity.
- The service took account of patients' individual needs and staff knew how to access a wide range of services to improve patient experience. For example, interpreters for those patients whose first language was not English, hearing loops, bariatric equipment, play specialists and dementia champions to meet the needs of patients.
- The service had a vision for what it wanted to achieve and workable strategy to turn it into action along with effective systems for identifying risks, planning to eliminate them or reduce them. Local leaders were visible, approachable and supportive to staff.

Summary of findings

- The radiology department had a comprehensive audit programme to improve performance and safety and managers across the trust promoted a positive culture that supported and valued staff.

Urgent and emergency services

Inadequate ● ↓↓

Key facts and figures

The emergency department at The Queen Elizabeth Hospital provides care for the local population 24 hours a day, seven days a week.

From April 2016 to March 2017 there were 62,317 attendances. The department was originally built for 40,000 attendances.

Out of all attendances, 37.4% resulted in admission to hospital, which is higher than the England average.

The department has a resuscitation room with three adult bays and one paediatric bay. The majors' area has eight cubicles and the minors' area has nine cubicles.

The paediatric area of the emergency department is open 24 hours a day, seven days a week and has three cubicles.

The adult emergency department has a dedicated mental health room.

There is an entrance for patients that self-present to the department and a dedicated entrance for ambulance arrivals.

The last inspection of the department took place in 2015, where urgent and emergency services were rated good overall. Safe was rated requires improvement and all other domains were rated good. The inspection found concerns regarding record keeping, checking of resuscitation trolleys, medicines storage, hand hygiene, the layout of the department and staffing in the paediatric area.

We carried out a short notice announced inspection of urgent and emergency care services on the 1 and 2 May 2018. We carried out an unannounced inspection on 10 May 2018. During the inspection visit, the inspection team spoke to 43 members of staff, including nursing staff, health care assistants, doctors, housekeeping staff, administrative staff, and managers. We also spoke to three paramedics from the local ambulance trust and three members of the mental health liaison team, provided by the local mental health trust. We spoke to 12 patients and relatives, and reviewed 26 patient records.

Summary of this service

Our 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:

- The service did not always have systems in place to ensure that staff were able to identify and respond appropriately to changing risks to people who used services. Non-clinical reception staff made decisions about the escalation of patients who may require urgent review without formal guidelines to base these decisions on.

Urgent and emergency services

- The design and use of facilities and premises in the emergency department did not always keep people safe. Cubicles in the minors' area of the department had been split into two to increase capacity. This had reduced the space within the cubicles to provide care and treatment, and meant that walled oxygen, suction and call bells were not available in all cubicles.
- The layout of the department meant that the majority of cubicles were not in view of the nurses' stations and this created a risk that there would be a delay in identifying and responding to deteriorating patients.
- Learning from serious incidents was not always robust; action plans did not include all areas of learning identified through the investigation process and there were delays in the completion of actions identified through incident investigations. We requested minutes from mortality and morbidity meetings but none were provided.
- The numbers and skill mix of nursing and medical staff were not always suitable for the needs of the emergency department. There were significant vacancy and turnover rates for both medical and nursing staff and as a result, the department was reliant on a significant amount of bank, agency and locum staff.
- The movement of staff around the department to meet increased demand in the resus and paediatric areas impacted on the nurse to patient ratio in the minors' area. An increasing number of 'majors' patients were being placed in the minors' area at times of high demand due to insufficient capacity and this raised concerns about nurses working on their own in the minors' area.
- There was not always evidence of regular review of resuscitation equipment. We raised concerns regarding the checking of resuscitation trolleys during our previous inspection and these concerns had therefore not been resolved.
- The trust target for mandatory training completion had not been met for any of the 10 mandatory training modules. Overall compliance was 66% for medical staff and 77% for nursing staff.
- Patients did not always receive a face-to-face assessment within the recommended time of 15 minutes. The median time from arrival to initial assessment was worse than the overall England median in all 12 months from February 2017 to January 2018.
- The facilities for conducting assessments of patients with mental health conditions in the department were not safe. However, the trust took action to ensure that facilities were made safe after concerns were raised during our inspection.
- Resuscitation equipment was not always readily available in all the areas of the department. However, concerns were raised during our inspection about the lack of a resuscitation trolley in the paediatric area and the trust took immediate action to move a resuscitation trolley into this area.
- Registered children's nurse staffing was not in line with national guidance in the emergency department as there were not enough registered children's nurses to work on each shift. As a result, adult trained nurses were working in the paediatric area and we did not have assurance that they had completed paediatric competencies. However, when concerns were raised during our inspection, the trust took action to ensure that all adult nurses working in the paediatric area had completed paediatric competencies.

However,

- Medicines storage had improved since our last inspection.
- Compliance with hand hygiene policies had improved since our last inspection.

Urgent and emergency services

Is the service effective?

Requires improvement ● ↓

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

- A significant number of clinical guidelines were out of date for review; meeting minutes from April 2018 showed that 92 emergency department guidelines were out of date and all guidelines reviewed during our inspection were out of date. This meant that staff were accessing clinical guidelines which were not always based on up-to-date evidence based national guidelines.
- Performance in national audits was mixed. There was limited evidence of learning and action when national audit results were in the lower UK quartile. We requested action plans for national audits and none were provided.
- We were not provided with evidence that urgent and emergency services were following a trust-wide process to ensure that compliance with new or updated National Institute of Health and Care Excellence (NICE) guidance was regularly reviewed.
- Appraisal completion rates were below the trust target. For example, only 68% of nurses and 70% of doctors had completed an appraisal.
- We were not provided with any evidence that pain management was audited, which was not in line with national guidance.
- There was not always oversight of the completion of competencies by staff in the department. For example, the completion of paediatric competencies by adult trained nurses working in the paediatric ED. However, the trust took action to address concerns raised during our inspection.
- Whilst there was positive multidisciplinary working amongst members of the emergency department team, this did not always extend to external colleagues and teams.

However,

- Staff were familiar with the Mental Capacity Act and could demonstrate how they would apply this in practice.
- The department had a full-time practice development nurse (PDN), who provided monthly clinical updates and monthly simulation scenarios for staff in the department.
- The department's unplanned re-attendance rate was consistently better than the England average between February 2017 and January 2018.

Is the service caring?

Good ● → ←

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

- We observed many examples of caring interactions between staff and patients during our inspection. The majority of patients provided positive feedback about the care provided by staff.
- Patients described staff as supportive and we observed several occasions where timely emotional support was being provided to recently bereaved relatives.

Urgent and emergency services

- Patients were routinely given forecasts about what would be happening with their treatment and patients were clearly told how to access staff when they had needs or concerns.
- Interactions between staff and patients were respectful and the majority of patients felt that they had been treated with dignity and that their privacy had been respected.

However,

- We observed three visibly upset and distressed relatives in the emergency department corridors, some of whom had just undergone a bereavement, who were not observed to be in receipt of timely emotional support.
- The privacy and dignity of patients was not always maintained. For example, several cubicles had been split in the minors' area of the department through the use of curtains and this resulted in a lack of privacy and dignity for patients receiving care in this area.

Is the service responsive?

Requires improvement ● ↓

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

- Data on access and flow through the department showed a declining picture in a number of metrics. For example, from November 2017 there was a decline in performance in the percentage of patients waiting more than four hours from the decision to admit until being admitted, the percentage of ambulance journeys with turnaround times over 30 minutes and the percentage of patients admitted, transferred or discharged within four hours. From February 2017 to January 2018 the trust's monthly median total time in A&E for all patients was consistently higher the England average.
- Policies and protocols in place to manage escalation and crowding lacked clarity. The frequent and extended use of the protocol during the winter of 2017/2018 indicated that the actions within it were not working effectively but no review or debrief had taken place by the time of our inspection in May 2018.
- The layout of the emergency department did not support good patient flow. There were five individual areas within the department, which meant that identifying peaks and demands on capacity was a challenge. This had been identified during our previous inspection but there had been no significant change to the layout of the department by the time of our inspection.
- Delays in the assessment and treatment of patients with mental health concerns in the department impacted on access and flow.
- Areas within the emergency department were not always being used as intended, and this impacted on flow through the department. For example, part of the clinical decision's unit was being used for medical patients rather than emergency department patients.
- The allocation and movement of staff in the department had an impact on access and flow. Only one nurse each was allocated to the paediatric and resus areas, and nurses working in minors therefore acted as back-up nurses for these areas when required, which impacted on the flow of patients through the minors' area.
- There were no regular huddles or board rounds amongst emergency department staff to review individual patients within the department and determine whether there were any delays in individual patients' pathways through the department.

Urgent and emergency services

- We identified patients during our inspection who had experienced significant delays, including a patient who had waited over six hours for a chest x-ray and a patient who had waited eight hours for a bed on a ward.
- Although admission avoidance provision was in place, including the ambulatory emergency care unit, the paediatric assessment unit and the rapid assessment team, these often had limited hours of availability, which therefore limited the number of admissions that could be avoided. In addition, the AEC had insufficient capacity to meet demand.
- Service leads recognised that the emergency department environment was not fit for purpose in terms of layout and size and therefore did not always meet the needs of local people.

However,

- The rapid assessment team (RAT) worked to ensure that appropriate discharge arrangements were in place for people with complex health and social care needs. The team carried out comprehensive assessments of health and social care needs and then worked to address these in order to facilitate discharge.
- A patient flow coordinator had been introduced into the department four weeks prior to our inspection to assist with improving ambulance handover times and achieving other national treatment time targets.
- Staff were knowledgeable about how to respond if a patient complained and the complaints we reviewed had been dealt with appropriately.

Is the service well-led?

Inadequate ● ↓↓

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

- Leaders either had not identified or had not taken action to address some of the concerns that we identified during our inspection. Whilst the trust was responsive to concerns raised during our inspection, this indicated that leaders were reactive rather than proactive in identifying and addressing concerns.
- Action had not been taken to address some concerns identified during our previous inspection in 2015.
- Learning from external reviews was not effectively used to make improvements. For example, the Emergency Care Improvement Project had carried out a review of the department in October 2017 and the majority of recommendations made had not yet been implemented by the time of our inspection in May 2018.
- There was no separate formal strategy or a medium to long term strategic clinical plan for urgent and emergency services. This meant that departmental leaders did not have clear objectives to work towards and did not regularly assess whether progress was being made.
- The processes that were in place to give leaders an oversight of performance was not being utilised effectively to drive improvement. Performance data was discussed but actions were not subsequently implemented to address concerns identified. There was limited evidence that audit findings were being used to implement improvements. We requested action plans for national audits and none were provided.
- There were not always robust arrangements for identifying, recording and managing risks. Some of the concerns identified during our inspection were not on the risk register and in some cases insufficient action was being taken to reduce or eliminate risks.
- Effective arrangements were not in place to ensure that the information used to monitor, manage and report on quality and performance was accurate, valid, reliable, timely and relevant. For example, all of the guidelines reviewed during out inspection were out of date for review.

Urgent and emergency services

- The matron responsible for the emergency department also had responsibility for other areas of the hospital, and staff noted that this impacted on the amount of time that the matron had available to focus on the ED.
- Senior nurse coordinators provided day-to-day management in the department but were usually not supernumerary and this limited the time that they had available to provide leadership.

However,

- Staff said that the clinical lead and matron were visible in the department and were supportive. Nursing and support staff felt supported by the senior nurse coordinators.
- There was a positive culture throughout the urgent and emergency service, and staff felt respected and valued by their colleagues and their leaders.

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.

Medical care (including older people's care)

Inadequate ● ↓↓

Key facts and figures

The trust provides a comprehensive medical service within an inpatient setting. The trust has two care of the elderly wards; one of these being a specialist environment for the care of patients with dementia. The trust has a full-time consultant ortho-geriatrician and there is also a seven-day service consultant-led frailty unit.

The trust stroke service has a hyper-active stroke unit (HASU) with four thromboembolism beds, supported by further acute and rehabilitation beds. Stroke and transient ischaemic attack (TIA) are seven-day services, and there is a thromboembolism nurse on-site 24/7.

The trust has three coronary care unit (CCU) beds, cardiology monitored beds and a dedicated cardiology in-reach service for the medical assessment unit (MAU). There is a respiratory ward, and in-reach is provided seven days per week.

The endocrine and diabetes service is consultant-led, supported by diabetes clinical nurse specialists. The diabetes service run insulin pump clinics and outreach community education to reduce incidence and hospital attendance.

Rheumatology has four clinical nurse specialists supporting the consultants, and is in the process of bringing an osteoporosis service into the trust. There is a full range of specialist neurology clinics, including memory, motor neurone disease (MND) and joint injection. The trust also has a consultant liaison service to provide support to two local community hospitals.

(Source: Routine Provider Information Request (RPIR) AC1 - Acute Context)

The medical care service at the trust has 292 medical inpatient beds located across 11 wards and units.

The trust had 40,368 medical admissions from December 2016 to November 2017. Emergency admissions accounted for 20,553 (51.0%), 222 (0.5%) were elective, and the remaining 19,593 (48.5%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 26,884
- Clinical haematology: 3,654
- Medical oncology: 2,497

(Source: Hospital Episode Statistics)

During our inspection we visited Leverington, Necton, Oxborough, Terrington, West Newton and West Raynham wards, as well as the discharge lounge, medical assessment unit and operations centre.

We spoke with nine patients, 10 relatives, and 49 members of staff including junior doctors, locum and substantive consultants, senior and junior nursing staff, health care assistants, a pharmacy technician, therapy assistant, housekeeping staff, and senior leaders. We also attended a staff huddle, ward round, and a multidisciplinary team meeting, and reviewed 18 patient records.

Summary of this service

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

Medical care (including older people's care)

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:

- The service did not have enough nursing staff to keep people safe from avoidable harm and to provide the right care and treatment. This was a breach of the Health and Social Care Act 2008 regulated activities regulations 2014 regulation 18: Staffing.
- For example, Oxborough and Terrington wards had vacancies of 56% and 38% respectively. The overall nurse vacancy rate in medicine was 21%, significantly higher than the trust target of 10%. Staff turnover and sickness rates were also higher than the trust targets. There was evidence that insufficient nursing staff numbers led to patients receiving poor care.
- There was high reliance on agency and bank nursing staff to cover vacancies, notably on Oxborough and Terrington wards with 26% and 20% agency staff use respectively. This included four occasions between January and March 2018 where medical wards (Leverington and Terrington) had been staffed by only agency nurses. This was a concern because agency staff could not access trust IT systems and there was a risk they did not have the appropriate competencies and sufficient induction to support them to safely treat patients.
- Medicines management processes were not robust. Data showed there had been an increase in medicines incidents over the last 12 months, from 23 in April 2017 to 45 in March 2018. We also witnessed medicines incidents during our inspection which we raised at the time.
- This was supported by concerns from staff we spoke with during inspection. For example, a staff member on Leverington ward told us they had reported seven medicines errors recently. They felt that the main reason for medicines errors was the lack of sufficient induction processes for agency staff to ensure they were familiar with prescription and medicines forms.
- Our concerns around medicines management were increased because it was not identified on the trust risk register meaning there was a lack of oversight and monitoring of the issue.
- There had been instances where staff had not been able to assess and respond to patient risk in an appropriate and timely way, due to staffing and capacity pressures. For example, on Terrington ward we saw a patient on the edge of their bed appearing distressed and pulling on their intravenous line, which we escalated immediately and a nurse went to check on them.
- This concern was reflected by feedback from staff on inspection and in a focus group we held prior to inspection, that they were not always able to meet basic needs such as feeding support and toileting and to respond to patient risks in a timely and appropriate way, due to reduced numbers. They felt it impacted on patient safety.
- National Early Warning Scores (NEWS) were not completed consistently, and appropriate escalation did not always take place, which posed a risk to patient safety. This was largely due to staffing and capacity constraints.
- The 90-95% target was not met for any of the 10 mandatory training modules shown above for medical staff. The resuscitation training module had the lowest completion rate with 51%.
- Patients' individualised care records were not completed or managed in a way that kept patients safe. Records were poor in their completion and clarity. For example, we saw records lacking in an overview of MUST scores; with incorrect early warning scores; and in an unclear order with loose sheets.

Medical care (including older people's care)

- We were not assured that incident reporting processes were consistently followed. Feedback and learning from incidents was not consistently shared among wider teams. This meant there was a risk of potentially avoidable patient safety incidents reoccurring.
- Checks on resuscitation trolleys were not consistently carried out and documented. There was no resuscitation equipment available in the discharge lounge, although after we raised this as a concern the trust planned to put a resuscitation grab bag in the discharge lounge.
- Staff did not have consistent access to all the equipment they needed to treat and respond to patients safely and appropriately.
- There was a high reliance on locum medical staff, meaning patients would not always receive sufficient continuity of care.

However:

- Staff awareness of safeguarding procedures was good and nursing staff were meeting the trust target for safeguarding training compliance.
- There had been no reported never events in the service between April 2017 and March 2018.

Is the service effective?

Requires improvement ● ↓

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

- Although there was a comprehensive local audit schedule on medical wards, there was limited evidence that audit results were acted upon as a means of continuous quality improvement for the service.
- There was limited sharing of audit results and involvement of the wider staff group in carrying out audits, to include all staff in working towards best practice and driving quality improvement.
- Weight and nutritional assessments were not always completed consistently and accurately. We were concerned that staff did not always have capacity or time to review these appropriately and there was no evidence of escalation of these concerns.
- The accurate and consistent completion of fluid balance charts was documented as a risk for Necton (respiratory) ward, due to communication issues, although there were actions in place to address this, which the ward manager said had led to gradual improvement.
- The service was performing worse than the England and Wales average for six of the seven standards relating to discharge.
- The proportion of patients seen by a Cancer Nurse Specialist according to the 2017 Lung Cancer Audit was 33.1%, which did not meet the audit aspirational standard of 90%, and was worse than the trust's 2016 results.
- The service did not perform well in the 2017 National Audit of Inpatient Falls; for example, the crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 7%, compared to a national aspirational standard of 100%.
- There were concerns around ensuring agency nursing staff and staff who had been moved to a different ward to cover gaps in rotas had the competencies and skills for the ward in which they were placed.
- Staff felt there were communication issues with external services including social care services and the community.

Medical care (including older people's care)

- Staff knowledge of mental capacity assessments was poor. Mental capacity assessments were not being completed appropriately and consistently.
- We were concerned that do not attempt cardiopulmonary resuscitation (DNACPR) orders were not consistently reviewed, updated and completed as they should have been. DNACPR records in patient notes were unclear.

However:

- The endoscopy service had achieved Joint Advisory Group on Endoscopy (JAG) accreditation in September 2017.
- Pain was managed well and staff had good access to the trust pain control team.
- The service had improved in the 2017 National Diabetes Inpatient Audit compared to the 2016 audit, with 78.6% of patients with diabetes reporting that they were satisfied or very satisfied with the overall care of their diabetes, which placed the service in the second quartile nationally.
- Junior doctors had the required supervision, teaching and support to maintain and develop their competencies.
- Staff reported good access to therapies such as physiotherapy, occupational therapy and speech and language therapy.

Is the service caring?

Requires improvement ● ↓

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

- There was not always good communication from staff to ensure patients were fully involved in and understood decisions, although this was due to time and capacity pressures on staff.
- Nurses felt they could not provide the level of emotional care and support to patients and relatives that they would like to because of capacity constraints.

However:

- Staff were, on the whole, compassionate and kind in their interactions with patients and relatives, although interactions were more rushed than staff would have liked due to low staff numbers and capacity constraints.
- Patients spoke highly of the nursing staff and their experiences of the care received.
- Friends and family test (FFT) results were good and the response rate was higher than the national average.

Is the service responsive?

Requires improvement ● ↓

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

- Access and flow was not being effectively and consistently managed at the time of inspection. This was linked to the low substantive staffing numbers and winter pressures meaning that additional escalation areas had opened, which were not always sufficiently staffed.

Medical care (including older people's care)

- There was an issue with medical outliers due to capacity and flow, particularly on Denver ward. Terrington ward (short stay) was often used as an additional capacity area for patients with a range of medical and surgical conditions. However, outliers were tracked and cared for by the medical team.
- Referral to treatment time (RTT) for admitted pathways had declined from being better than the national average in January 2017 to being worse than the national average in December 2017.
- We had concerns that discharge planning did not always take into account the particular needs of individual patients. We saw an example of this on Terrington ward, where a patient's notes did not contain a structured care plan and did not focus on this patient's wider medical, social and personal needs as part of discharge planning.
- These concerns were reflected by staff feedback from the focus group we held prior to inspection. Staff felt that there was a focus on quick discharges rather than ensuring all patient needs had been considered prior to discharge.
- There was inconsistency in whether terminally ill patients and their relatives could access free parking, depending on the ward on which they were treated.
- We had concerns about fast track arrangements for patients with terminal illnesses, as they were limited to patients with a prognosis of six weeks rather than three months as is common at many trusts
- We had concerns about call bells being unanswered for prolonged periods, especially at night.
- The trust did not have an electronic flagging system for patients with dementia.
- The service took an average of 35 days to investigate and close complaints, which was not in line with trust policy (30 days).
- We were not assured that learning from complaints was consistently shared with the wider staff groups, largely because staff did not have the time to attend briefings or read communications folders, due to low nurse staff numbers.

However:

- There were initiatives to meet the needs of patients living with dementia, such as longer visiting hours, encouraging families to bring in personal items or photos for patients, and a therapy dog.
- The trust had an electronic flagging system for patients with learning disabilities and there was a learning disability liaison team to support patients, families and carers and to provide advice to staff.
- There was a 'my hospital passport' system in place for patients with learning disabilities, which had been developed by the mental health team and the learning disability liaison service.
- The medical assessment unit used a dedicated triage nurse to support discharge and help flow through the service. They did not make clinical decisions but it allowed registered nurses on shift to focus on the most poorly patients.
- Within endoscopy, access and flow was organised, efficient and well managed. There were emergency slots reserved each day to ensure the service could cope with unexpected patient need.

Is the service well-led?

Inadequate ● ↓↓

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

Medical care (including older people's care)

- There was poor feedback about the support from the trust senior team, including concerns that they did not do enough to ensure staff voices were heard.
- Nursing leads told us they struggled to fulfil their managerial and support responsibilities due to low staffing which meant they worked clinically and were included in the staffing numbers most of the time.
- Due to the issues identified in relation to record keeping, staffing, mental capacity and outliers, we had concerns about the strength of governance processes in the service.
- Morale was low, largely due to the low nurse staffing numbers resulting in staff feeling they did not have the time and resources to care for patients as well as they would like to.
- There was a poor culture due to staff feeling their concerns were not listened to or acted upon by the senior team, leading to staff feeling they wanted to leave and feeling disengaged and stressed.
- There was a poor culture around feedback and learning from incidents whereby staff did not have the time to spend on this and were expected to 'just get on with it'.
- We were concerned that risk management was not effective. The risk register did not reflect all the risks we found on inspection, such as those around nutrition and hydration, mental capacity assessments, patient records, and agency staff induction procedures.
- There was no evidence that actions to address the main risks on the register, namely in relation to low nurse staffing, were having any meaningful effect. Feedback from staff indicated it was worsening.
- Although staff were highly committed to their work, there was a lack of systems in place to reward staff, encourage their development, and continuously engage them.
- There was a lack of clear strategy to ensure the development, improvement and sustainability of the service; local management did not demonstrate effective strategic oversight.

However:

- There was some evidence of local leads trying to improve communication and engagement with staff; for example, an informal twice-daily huddle had been implemented on Necton ward as an opportunity for staff to raise any issues or queries and for the ward lead to give an overview of the day.
- Medical services were included in the trust wide three year clinical strategy.
- We saw staff were supportive of each other and pulled together as a team despite high vacancies and other pressures impacting on them.

Areas for improvement

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

Surgery

Requires improvement ● ↓

Key facts and figures

The Queen Elizabeth hospital provides a range of elective and emergency surgical services, including general surgery, breast surgery, trauma and orthopaedics, urology, ophthalmology, ear nose and throat (ENT), oral surgery, gynaecology and chronic pain services.

The surgery service includes 126 inpatient beds, across four surgical wards and a surgical assessment unit. Surgery wards include Denver ward, which has 28 beds, Elm ward, which has 21 beds, Gayton ward, which has 32 beds, Marham ward, which has 33 beds and the surgical assessment unit, which has 12 beds.

The trust provides a day surgery service, including 45 day stay beds, four day surgery theatres and one day surgery treatment room. The trust has seven main theatres, three of which have laminar flow. There is also one obstetric theatre.

Elective surgical services are delivered from a stand-alone pre-assessment department, elective ward with 12 ring-fenced beds (beds used only for elective patients), the day surgery unit and main theatres. Services are also delivered in satellite areas, which include minor surgery and ophthalmology services at a medical centre in Littleport.

The emergency surgical service includes an assessment unit, wards and ring-fenced trauma bed (a bed used only for orthopaedic trauma patients). The trust is a tertiary site for vascular surgery with two vascular networks and some complex surgery.

The trust had 27,150 surgical admissions from December 2016 to November 2017.

Emergency admissions accounted for 5,909 (22%), 18,632 (69%) were day case, and the remaining 2,609 (10%) were elective.

During this inspection, we visited 11 clinical areas, as follows:

- Surgical pre-assessment clinic, which provides clinical assessment for patients before surgery.
- Feltwell ward, which was the temporary location of the elective admissions unit. This is a pre-operative area where patients are prepared for their operation on the day of surgery.
- The surgical assessment unit (SAU), which provides assessment and treatment for surgical admissions, before transfer to a speciality ward or discharge.
- Denver ward, which is a surgical ward specialising in post-operative care of patients who have received emergency surgery.
- Gayton ward, which is a trauma and orthopaedics ward.
- Elm ward, which is an elective surgical ward.
- Marham ward, which is an elective surgical ward.
- Day surgery unit
- Main theatres
- Theatre recovery, which is the area where patients are cared for immediately after surgery.
- Discharge lounge where patients wait before discharge from the hospital.

Surgery

The last comprehensive inspection of the surgery service took place in July 2014. We rated the service as good for the key questions of safe, effective and caring, with the key question of responsive rated as inadequate and the key question of well led as requires improvement. This resulted in a rating of requires improvement overall. As the trust was in special measures at this time, additional enforcement action was not taken, but concerns were raised with the trust and monitored through the special measures action plan. Concerns related to service planning, admissions the day before surgery, the low number of day cases, the high number of cancellations, privacy and dignity concerns in the breast care unit, communication and governance structures.

We carried out a focused inspection in June 2015, where we inspected two key questions (responsive and well-led). We rated responsive and well-led as good. This resulted in a rating of good overall. We found improvements in relation to the number of cancelled operations, referral to treatment times and governance arrangements and saw there were plans in place to move the breast care unit. Concerns related to responsiveness in relation to the hip fracture pathway and urology clinics, the oversight of risk in urology, decontamination of flexible cystoscopes, the lack of a formal consultant on-call rota to cover emergency gastric bleeds and the effectiveness of staff training on dementia.

At this inspection, we re-inspected all key questions. We rated safe, effective, responsive and well-led as requires improvement, and caring as good, providing a rating of requires improvement overall.

Our inspection was announced at short notice to ensure that everyone we needed to talk to was available.

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

During the inspection visit, the inspection team spoke with 11 patients and relatives. We spoke with 38 members of staff including consultants, junior doctors, nursing staff, allied health professionals, theatre staff, support staff and managers. We reviewed 17 patient care records.

We also observed theatre safety briefings, handovers and reviewed information including meeting minutes, audit data, action plans and training records.

Summary of this service

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

- Compliance with mandatory training was below the trust target for medical and nursing staff. The trust target was 90% for medicine management training and 95% for all other modules. The trust target was not met for any of the 10 mandatory training modules for medical staff and was only met for one of the nine modules for nursing staff. For medical staff, the resuscitation training module had the lowest completion rate with 64 % and for nursing staff the fire safety training module had the lowest completion rate with 70%.

Surgery

- Compliance with safeguarding training for medical staff was below the trust target. Medical staff did not meet the trust target of 95% for any of the three safeguarding training modules. Safeguarding adults level one training had the lowest completion rate with 80%.
- We had concerns about how staff controlled infection risk. Staff compliance with infection prevention training was 68% for medical staff and 77% for nursing staff, both of which were below the trust target. Results of hand hygiene audits showed variable compliance and some staff did not follow infection prevention and control procedures.
- The arrangements for disposing of waste on SAU and Elm ward presented a risk in terms of infection control. The two ward areas shared a single sluice room, which meant there was a risk of spreading infection between the two wards. Staff told us about an occasion where Elm ward had been closed due to C-difficile infection but staff had to take infectious waste to the sluice situated on SAU.
- There were some gaps in procedures to ensure the safety of equipment. One anaesthetic machine and one malignant hyperthermia trolley (which contains equipment and medicine to counteract a severe reaction to anaesthetic) did not have clear checklists for staff to follow in relation to safety checks.
- Staff did not store patient care records securely in all areas, which meant there was a risk of breaches to patient confidentiality.
- Staff did not always store, prescribe and administer medicines well. The process for monitoring medicines refrigerator temperatures was inconsistent and we had concerns around checking of controlled drugs. We saw examples of medicines not being stored securely and noted an error in the prescription of a patient's medicine.
- We found that not all aspects of the World Health Organisation (WHO) and five steps to safer surgery checklist were effectively implemented or audited. Despite four previous never events processes were not in place to ensure changes in practice and compliance of the safety checks had been embedded. Observational audits of the WHO checklist were only introduced in March 2018 and were limited to a small sample size (1.7%) and did not encompass all five steps.
- Serious incidents were not always identified, reported and investigated in a timely manner. Staff had some knowledge of learning from incidents but opportunities for learning from incidents were not maximised in all areas.
- We were not assured that staff attended regular morbidity and mortality meetings in order to discuss and learn from adverse outcomes.
- Data from the patient safety thermometer did not demonstrate sustained improvement in safety outcomes and we were not assured that learning and actions following incidents were shared effectively in all areas.
- When things went wrong, staff did not always carry out the duty of candour (a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Nine staff expressed concerns about nursing staffing and staff told us that staffing shortages affected their ability to provide one to one care and rehabilitation. Staff rotas on Elm ward and Gayton ward showed a high number of unfilled shifts and data provided by the trust showed high vacancy rates in some areas. Senior staff were aware of the areas affected by staffing shortages and information provided by the trust after inspection showed improvements in nursing staffing levels.
- There was a high level of bank and agency staff use within the service. Staff told us this could affect the service because agency staff did not have access to the electronic system for arranging patients' discharge and had variable skill sets.

However:

Surgery

- 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 understood how to raise a safeguarding concern. Nursing staff met the 95% target for all three safeguarding training modules.
- Staff we spoke with knew how to recognise and report incidents.
- Staff collected safety information and shared it with staff, patients and visitors.
- Staff had addressed concerns raised at our previous inspection around the decontamination of flexible cystoscopes.
- Staff had addressed concerns raised at our previous inspection around the consultant rota for gastric bleeds.

Is the service effective?

Requires improvement ● ↓

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

- Staff knowledge relating to the Mental Capacity Act 2005 was poor. Staff were not confident in their knowledge of how to support patients who lacked the capacity to make decisions about their care and patient care records showed omissions in relation to mental capacity assessments. This meant there was a risk that patients who lacked the capacity to consent to treatment may not have been supported appropriately to make decisions and that decisions may not have reflected the patients' best interests.
- Records provided by the trust did not assure us that staff had received training on Deprivation of Liberty Safeguards (DoLS) legislation and staff we spoke with lacked knowledge in relation to this legislation. This meant there was a risk staff would not recognise when a vulnerable patient was being deprived of their liberty.
- We were not assured that procedures to apply for and receive authorisation for DoLS were consistently followed. This meant there was a risk that patients could be deprived of their liberty without the appropriate processes in place to safeguard their rights.
- The local clinical audit programme was not effectively implemented on all wards. Participation in local audit was variable and dependent on individual ownership. We were not assured that learning from audits was shared with all staff. This meant there was not a consistent approach to improving the quality of the service.
- There was a lack of evidence that learning and improvement actions were implemented following participation in national audit. We were not provided with any evidence of action plans following the 2017 National Hip Fracture Database audit or the 2016 National Oesophago-Gastric Cancer Audit.
- Appraisal rates for medical and nursing staff within the service were 82% and 83% respectively, both of which were below the trust target of 90%.

However:

- Staff were supported to attend additional training courses to improve role-specific competencies.
- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to meet patients' needs.

Surgery

- The service monitored the effectiveness of care and treatment through participation in national audit.

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 had addressed concerns from our last inspection around privacy and dignity in the breast care unit.
- 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.

Is the service responsive?

Requires improvement ↓

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

- The planning of services did not always meet the needs of local people. The location of the elective admissions unit was not suitable and had negatively impacted the experience of some patients.
- Information displays showed limited evidence of changes implemented in response to patient feedback.
- In two specialities, patients could not access services in a timely way. Referral to treatment times for orthopaedic and ENT surgery were worse than the England average.
- Access and flow was not always managed effectively within the service. There was a high number of medical outliers on surgery wards and the ambulatory area on the surgical assessment unit was not open due to staffing shortages. Initiatives to improve patient flow were not embedded in the service.
- Information relating to the individual needs of patients living with dementia was not always completed in a timely way.
- We were not assured that learning from complaints was shared with staff on all wards.

However,

- Referral to treatment times for oral surgery, plastic surgery, urology, ophthalmology and general surgery were better than the England average. The percentage of cancelled operations at the trust where the patient was not treated in 28 days was generally lower than the England average.
- The average length of stay for elective and emergency patients was lower than the England average.
- Staff adapted their communication to meet patients' individual needs and could access specialist staff to support patients with complex needs.
- The service treated concerns and complaints seriously and investigated them. Staff could give examples of actions taken in response to complaints.

Surgery

Is the service well-led?

Requires improvement ● ↓

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

- Governance processes were not embedded on all wards and we were not assured there was a systematic approach to continually improving the quality of services. For example, implementation of local clinical audit varied across wards and we were not assured that there were effective processes for sharing learning from audits, complaints and incidents on all wards.
- We were not assured that systems for identifying and managing risks were always effective. Some concerns we identified during inspection, for example those relating to mental capacity assessments, duty of candour and mandatory training, had not been identified as risks. The risk register did not identify clear ownership of each risk.
- We found some gaps in leaders' oversight of quality and reporting of performance to the board.
- The leadership structure within the service was not fully embedded and staff gave variable feedback about the response from leaders to their concerns.
- Information management systems did not always provide staff with the information needed to meet patients' needs. Agency staff did not have access to IT systems and medical staff told us systems for making referrals and requesting investigations were confusing.
- Staff knowledge of the trust's vision and values was variable.
- Due to recent changes in the trust's operational structure, the development of a service specific vision and strategy for surgery services had been delayed. There was no service specific vision and strategy in place at the time of inspection.

However,

- Most staff described a positive culture that supported and valued staff.
- The trust had made significant investment in theatres, in order to support the training of doctors and ensure theatres were appropriately equipped for laser surgery.

Areas for improvement

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

Maternity

Inadequate

Key facts and figures

Queen Elizabeth Hospital provides maternity services across West Norfolk, North and North-East Cambridgeshire and South Lincolnshire. From October 2016 to September 2017 there were 2,203 deliveries at the trust.

The maternity service includes an antenatal clinic and an antenatal day assessment unit at both the Queen Elizabeth Hospital and the neighbouring hospital at Wisbech; Waterlily Birth Centre, the Central Delivery Suite and a combined ante and the postnatal ward at the Queen Elizabeth site. The community midwifery teams provide a home birth service, parenting classes, hypnobirthing and postdate aromatherapy clinics. The choice of a pool labour or birth was available in the midwife-led unit and the delivery suite.

The Queen Elizabeth Hospital has 25 maternity beds within Castleacre ward. There is also a delivery suite and the Waterlily birth centre. Waterlily birth centre is a midwifery led centre for women and has two birthing suites and a bereavement suite.

The last inspection of the service took place in June 2015 where maternity and gynaecology services were rated as requires improvement overall.

We carried out a short notice announced inspection of maternity services on 1 and 2 May 2018, followed by a further unannounced inspection on 10 May 2018. We also spoke with consultants and service leaders on our well-led inspection on 19 June 2018.

During the inspection we visited the central delivery suite, the pre and postnatal ward (Castleacre ward), Brancaster ward which ran antenatal and postnatal clinics, the day assessment unit, Appleton ward which held the early pregnancy assessment unit and the maternity facilities at Wisbech.

We spoke with 29 members of staff including midwifery and nursing staff, medical staff, housekeeping staff, student midwives, maternity support workers, the head of midwifery, matrons for the service, the practice development midwife, the deputy operations manager, the clinical lead and the lead midwife for risk and governance. We spoke with six women who had used the service and four women's relatives. We reviewed the care records for six women who had used the service and three completed patient prescription charts.

Summary of this service

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings. We rated Maternity services as inadequate.

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

Is the service safe?

Inadequate

We rated safe as inadequate because:

Maternity

- The service did not meet the trust training targets for mandatory training. The service had low levels of compliance with resuscitation training, compliance was 65% for medical staff and 73% of midwifery staff. Infection prevention and control training compliance was 43% for medical staff and 66% for midwifery staff. This posed a safety risk that a significant proportion medical and midwifery staff were not trained to deal with resuscitation and may lack an awareness of infection prevention and control.
- The service did not meet safeguarding training targets and had a low level of midwives trained in children's safeguarding Level 3 at 54%. Staff we spoke with on inspection told us that they had not received training on Female Genital Mutilation. This posed a risk that staff may not be trained to recognise and report certain types of abuse that women who have used the service have experienced.
- Staff did not currently participate in multidisciplinary scenario based simulations for obstetric emergencies. Whilst the service had plans for skills and drills sessions which would include scenario based simulations there was no timeline to implement these. This meant that the service had not practised its procedures for obstetric emergencies such as shoulder dystocia, vaginal breech birth, postpartum haemorrhage and maternal or neonatal resuscitation.
- The design, maintenance and use of facilities and premises at Wisbech did not keep people safe. The facilities had only one combined entrance and exit which involved accessing the service through a narrow staircase with no lift access. This posed a risk to women should they deteriorate and need to be evacuated. We raised this issue with the trust following our inspection and the service took action to address some of the immediate issues. The service had plans to reallocate but these had not been finalised.
- The environment in the Early Pregnancy Assessment Unit risked the safety of service users. There was a wall and filing cabinets between the scan room and the door, which meant that women could not be safely transferred in the event of a medical emergency. There was nowhere to lay down a miscarrying woman should they deteriorate.
- There was a lack of a formalised process to ensure that consistent care was given to women with high-risk care pathways, such as twin pregnancies. Women did not routinely see the same consultant and experienced delays in care planning.
- The booking process for consultant-led antenatal clinics was not effective and therefore posed a risk that women would not be seen by a consultant until late stages of their pregnancy meaning that obstetric problems could go undetected. Referrals within the service were not tracked or monitored regularly resulting in missed referrals.
- We were not assured that the service's checking processes were robust for resuscitation equipment and emergency medicine. We found that there were gaps on the resuscitation trolley checks on Castleacre ward on two occasions in April 2018 and on one occasion in both January and February 2018. We found out of date emergency medicine on the paediatric resuscitation trolley on Castleacre ward. This posed a risk that out of date medication could have been administered to a child.
- Staff told us that clinicians did not consistently use the World Health Organisation (WHO) and five steps to safer surgery checklist in obstetric theatres. This heightened the risk that an incident or never event could occur in theatres as procedures and checks were not being adhered to.
- There was limited information written in women's records regarding care planning and we identified instances where antenatal appointments had not been recorded in women's electronic records. The lack of continuity of consultants meant a potential risk to continuity of care for high-risk women.
- We were not assured that incidents were being investigated appropriately. Staff told us that consultants within the service downgraded levels of harm on incidents inappropriately and we found incidences where incidents had been reported as no harm but women had suffered short-term harm or the incident resulted in further treatment. This reduced the opportunity of shared learning and meant potential re-occurrence.

Maternity

However:

- The service had an effective system to ensure electrical testing and servicing of equipment was conducted within required time periods.
- All areas of the maternity service we visited were visibly clean and we observed staff adhering to national guidance on infection control practices.

Is the service effective?

Requires improvement

We rated effective as requires improvement because:

- The service had a significant number of guidelines that were not within their review date. The service had 54 outdated guidelines out of 131. This posed a risk that patient pathways and care and treatment were not being given in line with national guidance.
- We were not assured that the service used data to improve patient outcomes. The service conducted one local clinical audit in the year 2017/2018 and had not completed the actions from this at the time of our inspection.
- We were not assured that the service ensured staff were competent for their roles. The medical appraisal rate was 50% and the service did not keep records of medical staff's training. The General Medical Council (GMC) national training survey showed that for obstetrics and gynaecology the service had below the national average results for educational governance, curriculum coverage, adequate experience, induction, supportive environment, teamwork, reporting systems and clinical supervision. This suggested that junior medical staff within the service were not having their training needs adequately supported to ensure effective and quality care was being delivered to women using the service.
- The service had poor training rates in relation to cardiotocography (CTG) training, compliance rate for medical staff was 14.28% out of a possible 21 staff and for midwifery staff was 61.68%. The lack of CTG training compliance for medical staff posed a real and substantial risk to women and their babies.
- Staff within the service did not work together to assess, plan and deliver care and treatment for women and there were not effective systems of communication between all members of the team. Staff reported fractured working between the medical team and midwives and we observed a lack of multidisciplinary input on our inspection. We found that this prevented care being delivered and reviewed in a coordinated way.
- We were not assured that the service had effective arrangements in place for women who experienced mental health issues. There was no clinic or consultant lead for peri-natal health within the service at the time of our inspection.

However:

- Staff gave women enough food and drink to meet their needs and improve their health. The service supported new mothers with breastfeeding.
- Women's pain needs were assessed in a timely way and women reported that their pain was well managed.

Is the service caring?

Good

Maternity

We rated caring as good because:

- Staff cared for women with compassion. Feedback from women confirmed that staff treated them well and with kindness.
- Staff involved women and those close to them in decisions about their care and treatment.
- Staff provided emotional support to women to minimise their distress.

Is the service responsive?

Inadequate

We rated responsive as inadequate because:

- Vulnerable service users were not prioritised by the service and therefore services provided by the trust did not always reflect the needs of the population served. Vulnerable women include service users with complex social factors such as alcohol or drug misuse, domestic abuse victims, women aged under 20 and those with difficulty reading and speaking English. The service ran a limited number of vulnerable service-user antenatal clinics and the demand exceeded the number of appointments available and there was no clinic or consultant lead for peri-natal mental health.
- The service had a lack of specialist midwives for women who had complex social factors. The service did not have specialist midwives for teenage pregnancy, despite teenage pregnancy rates being higher than the national average in west Norfolk. The service also did not have specialist midwives for homelessness, substance abuse or domestic abuse victims despite midwifery staff telling us that a high number of these women used the service.
- The booking process for consultant-led antenatal clinics was not effective; there was no tracking or monitoring of referrals. Referrals were regularly lost in the internal post resulting in high-risk service-users experiencing delayed or missed appointments. This posed a risk that women would not be seen by experts in time for antenatal testing and that underlying obstetric problems could go undetected.
- The arrangements for women who miscarried before 16 weeks were not appropriate, they were placed on elm ward which was a surgical ward. Whilst staff tried to ensure women were cared for in side rooms this was not always possible.
- We were not assured that the service ensured that women who required a termination for urgent medical reasons received care promptly to minimise further risk to health.
- The waiting area arrangements for antenatal clinics on Brancaster ward were unsuitable. The waiting room was shared with gynaecology which meant that gynaecological patients with fertility concerns were seated with pregnant women attending antenatal clinics.
- The environment of the bereavement suite was unsuitable. The room was located on the waterlily birthing unit meaning that women who were suffering a miscarriage or stillbirth were placed in close proximity of women giving birth. This posed a risk to the psychological wellbeing of women.
- The service did not have a maternity section on their website or any social media accounts which meant that limited information was available to women wishing to use the services.
- The trust took an average of 42 days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be closed within 30 days.

However:

Maternity

- The service had improved since our June 2015 inspection by now offering a full choice between home birth services, midwifery led services in the waterlily midwifery led birthing unit and the obstetric led central delivery suite.

Is the service well-led?

Inadequate

We rated well led as inadequate because:

- Issues with culture and consultant engagement within the service had not been resolved despite being raised on our June 2015 inspection. We found that the leaders, both midwifery and clinician, could not work together and did not demonstrate integrity on an ongoing basis. We were not assured that leaders understood the challenges to quality and sustainability of high quality patient care.
- The service did not have a strategic plan for the maternity service. This meant that the department did not have clear objectives to work towards and did not regularly assess whether progress was being made.
- The culture within the service did not centre on the needs and experiences of people who used the service. Staff we spoke with were very emotional and repeatedly told us that obstetric consultants did not engage with the midwives and the senior leadership team for the service. Consultants within the service told us that they didn't receive support from the executive team, were often expected to work long hours and that members of the midwifery team did not respect them and their clinical decision making. Leaders within the service did not identify actions needed to address the cultural issues within the service.
- There were not effective structures, processes and systems of accountability in place to support the delivery of good quality and safe care. In the last year the service had introduced incident review panels and guideline meetings to strengthen their oversight of risk and best practice within the department. However, we found that these were poorly attended by consultants, there was little engagement with the processes from clinical staff and fractured working relationships prevented systems from being effective.
- We were not assured that governance arrangements for mandatory training compliance were effective. Mandatory training compliance rates were low for safeguarding children Level 3, resuscitation, infection prevention and control and Cardiotocography training. In the services clinical governance meetings the low levels of compliance had not been identified, discussed or actions put in place.
- We found that there were not comprehensive assurance systems of risk within the service. We were concerned that risks were not escalated appropriately and that the structures and processes for risk management did not allow risk actions to move progressively. Risk register items did not move progressively after being placed on the register and mitigations and actions on the risk register did not adequately address the issues. During our inspection we found that risks were not identified by the trust and did not feature on their risk register despite being raised by staff members as risks to the inspection team.
- There was not a systematic programme of clinical and internal audit in the service to monitor quality. We found that the service had not completed any local audit reports in the maternity service since May 2017. We were not sent any audit action plans for national audits and the action plans for the local audits contained actions that had not been completed in a year.
- The service did not have any consultant midwives or any plans to employ one. This did not comply with national guidance.
- We were not assured that the leaders and staff within the service strived for continuous learning, improvement and innovation.

Maternity

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

Queen Elizabeth 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 were1,169 in-hospital deaths in the year from December 2016 to November 2017.

Specialist palliative care services are provided through a service level agreement with the local community health trust, as part of the West Norfolk integrated palliative care service. The specialist palliative care team (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 Sunday between the hours of 9am and 5pm. Out of hours advice and support is provided through the on-call palliative medicine consultant.

The trust also employs a small end of life care team that leads and coordinates on end of life care in the hospital. This team consist of an end of life care facilitator and a fast track co-ordinator.

The trust is in the process of implementing palliative and end of life care champions within each clinical area and team. Champions are given additional ongoing training to support them within their roles. This is undertaken by the end of life care facilitator.

During this inspection we visited 11 wards and units at Queen Elizabeth Hospital, including older people's medicine wards, stroke ward, the accident and emergency department, hospital mortuary, and the hospital chapel. We spoke with 25 members of staff, which included medical and nursing staff, allied health professionals, the EOLC team, the chief nurse, porters, chaplaincy, mortuary and bereavement staff. We spoke with two patients who were at the end of their life and two patients' relatives. We reviewed care records for six patients receiving palliative and end of life care, 19 do not attempt cardiopulmonary resuscitation (DNACPR) records and five prescription charts throughout the inspection.

Summary of this service

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

- Patient care records were not completed or managed in a way that kept patients safe. Records were poor in their completion and clarity. Records were paper based and we found them very difficult to review as they were not filed in order with some loose sheets.
- The trust's individualised plan of care (IPOC) for patients receiving end of life care was in the process of being rolled out to all wards. However, the process was not fully embedded and during our inspection there was no evidence of the IPOC in use.

End of life care

- The trust target for mandatory training completion had not been met for nine of mandatory training modules. Overall compliance was 79.7%
- Palliative consultant staffing was not in line with guidance from The Association of Palliative Medicine for Great Britain and Ireland, and the National Council for Palliative Care, which recommend there should be a minimum of one consultant to 250 beds. The trust has 483 inpatient beds, which would require at least 2 WTE consultants. The trust employed one WTE speciality doctor for palliative care and was recruiting for a palliative consultant.
- There were inconsistences in how medication was prescribed and recorded. In two of the six prescription records we reviewed, one record had three different 'as required' antiemetics (anti-sickness drugs) prescribed with no clear indication of which ones to use when. In another prescription record two different types of painkillers were prescribed with no directions on the prescription chart for when each medicine should be used.

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 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 planned for emergencies and staff understood their roles if one should happen.

Is the service effective?

Inadequate ● ↓↓

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

- The Individual plan of care (IPOC) for the anticipated last days of life was recognised as a priority for care according to the Leadership Alliance for the Care of Dying People: A national framework for local action 2015-2020. The trust had piloted an individualised plan of care but this was yet to be fully implemented. We found this was not in use across the trust. There was no formal monitoring or audit to ensure implementation of the IPOC was embedded.
- Although there was some local audit schedule in EOLC, there was limited evidence that audit results were acted upon as a means of continuous quality improvement for the service.
- The trust's 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms were not always completed in line with national standards or the trust's own policy. Of the 19 DNACPR records we reviewed,12(63%) were completed in line with Resuscitation Council UK guidelines. Seven had documented that the patient did not have mental capacity. This meant a mental capacity assessment should have been completed for these patients. In five records, the mental capacity assessment was completed many days or weeks after the DNACPR was completed and put in place (delay of completing the mental capacity assessment being between four days and 36 days). The remaining two records did not have any evidence of mental capacity assessment or best interest decision documented.
- 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.

However:

- The service provided care and treatment based on national guidance and evidence of its effectiveness.

End of life care

- 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 SPCT provided a seven-day service which was an improvement from the last inspection.

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?

Good ● ↑

Our rating of responsive improved. We rated it as good because:

- The service took account of patients' individual needs. Staff took account of the cultural, 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 'purple tree' magnet around their bed space on each ward's white board for ease of identification and discussed at board round.
- 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 end of life care team and discussed at the EOLC steering group. Staff were aware of themes in complaints around end of life care and could identify areas of learning.
- The trust had improved the monitoring of patient preferred place of care (PPC) and preferred place of death (PPD). The trust target for recording PPC / PPD was 85%. Data provided showed that, between July 2017 and March 2018, 100% of patients referred to the specialist palliative care team had a PPC recorded.
- The trust had also improved monitoring the timeliness of fast track discharge. Data from January to April 2018 showed of 132 patients referred for fast track discharge, 98 (74%) died in their PPD, with 33 (25%) not achieving their PPD.

Is the service well-led?

Requires improvement ● ➔ ➔

End of life care

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

- The end of life care strategy was only approved in February 2018 and therefore had not been embedded fully.
- At the time of the inspection, results of a recent formal bereavement survey were not available. There was no local survey, to gather the views and experiences of bereaved relatives.
- The EoLC dashboard was still being embedded. Several points of information and raw data were incomplete, such as reasons for discharge delays. Therefore, information was not available at the time of inspection to evidence how the data would be analysed and used for service improvement.
- Implementation of various initiatives such as the amber care bundle and the individualised plan of care (IPOC) have been very slow due to lack of engagement from the medical team. In addition, due to staff shortage on the wards, training had to be cancelled, which meant the IPOC had not been fully rolled out or effectively used.
- At the last inspection in June 2015, it was identified that the mortality and morbidity meetings and reviews did not have palliative care consultant input. During this inspection we did not see any evidence that this had improved. The minutes from the mortality and morbidity meetings from January 2017 to April 2017 showed that reviews were focused on the cause of death and not the process of death or the care at the end of life.

However:

- The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. The chief nurse 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

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

Outpatient services at the Queen Elizabeth Hospital King's Lynn are provided in a number of locations in the main hospital and in neighbouring hospital in Wisbech and various GP medical practices in Fakenham and Littleport.

The trust provides outpatient services for a range of specialities including general outpatients; surgery; women and children's services; ophthalmology; ear, nose and throat (ENT); dental and oral surgery; trauma and orthopaedics; pain; rheumatology; stroke clinics; elderly care; haematology/oncology; breast care; therapy services; audiology; podiatry; and paediatrics. The trust has a range of specialist neurology clinics, including memory, motor neurone disease (MND) and joint injection and is in the process of introducing an osteoporosis service.

Outpatient clinics are supported by multidisciplinary teams including general registered and unregistered nurses, nurse specialists and allied health professionals. Allied health professionals such as audiologists, orthoptists, therapists and specialist nurses run outpatient clinics alongside the medical teams.

On this inspection we visited the services provided at The Queen Elizabeth Hospital King's Lynn and not the outpatients clinics provided at the other locations. We visited a range of clinics in the main outpatients (OPD), West Dereham unit, Roxburgh Unit paediatric OPD, Breast Care Unit, Macmillan Unit, gynaecology, chronic pain, and physiology investigation clinics. We spoke with 39 staff including nursing, medical, physiologists, senior staff and administrative staff. We met with 10 patients and relatives who shared their views and experiences of the OPD service. We observed how people were being cared for and reviewed 21 care/treatment records.

We also reviewed national data and performance information about the trust, and a range of policies, procedures and other documents relating to the operational organisation of the OPD.

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:

- Main outpatient staff were not trained to level three safeguarding for children despite being involved in their care.
- We were not assured that World Health Organisation (WHO) and five steps to safer surgery checklists were consistently completed.
- Equipment was not always suitable for use. In the Roxburgh Unit paediatric outpatient resuscitation grab bag contained two paediatric airways which were out of date in November 2017.
- We found inconsistencies with IPC measures such as non-wipeable furniture, toys in children's area and lack of records to ensure monitoring was taking place.

- The environment did not always meet the needs of the service. For example, the dental laboratory was generally in need of refurbishment, and the ophthalmology clinic signage was poor. This had not improved since the previous inspection.

However:

- 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 prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time. This was an improvement since the last inspection.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care. Records were stored safely to protect patient confidentiality. This was an improvement since the last inspection.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service had enough staff with the right qualifications, skills, and experience to keep people safe from avoidable harm and to provide the right care and treatment.

Is the service effective?

Not sufficient evidence to rate

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

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and 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 had access to up-to-date, accurate and comprehensive information on patients' care and treatment. Patient records were paper based but there was up to date electronic access to results and consultation letters.
- 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.
- There was some innovative practice that benefitted patients such as 3D scanning for hearing aids in the audiology clinic and percutaneous tibial nerve stimulation in the gynaecology clinic.
- There was a dedicated chronic pain clinic, that involved a range of health professional staff to provide a complete approach to pain management. This was in line with the Core Standards for Pain Management services UK (Faculty of Pain Medicine 2015).

However:

- The service did not routinely audit the effectiveness of care and treatment and use the findings to improve them.

Outpatients

- The service did not ensure that the most up to date national guidance was available for staff to refer to. There were out of date paper copies kept in departments which meant staff referring to them did not have the most recent versions.

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 ensured that patient's privacy and dignity were protected when providing care.
- The Friends and Family Test (FFT), for OPD was positive with an overall recommendation of 96.5% between March 2017 and February 2018.
- 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 service had specialist nurses who provided both support in clinic and by telephone with advice lines for patients to contact.

Is the service responsive?

Requires improvement

We rated responsive as requires improvement because:

- The average waiting times of patients being referred for non-cancer treatment declined between June 2017 and March 2018. Non-admitted referral to treatment pathway rates were 81% against the operational standard of 92% and the England average of 87%. This meant that patients were waiting longer for appointments after being referred by their GP.
- Patients with cancer were not always seen in line with national guidance timeframes. Between October 2017 and March 2018, the percentage of patients commencing treatment within 62 days of referral declined to 81.2% against an operational standard of 85% with the England average at 84.6%.
- There was no key performance indicator to monitor whether clinic spaces were being used to optimum capacity and the trust did not record or monitor clinic utilisation. There was no formal process for monitoring clinic wait time and delays despite staff acknowledging that this was a concern.
- The average time taken to investigate and close complaints was 46 days which was not in line with their complaints policy.
- Car parking facilities did not always meet demand, with patients reporting that they often had difficulty parking for clinic appointments.

However:

- The trust had concentrated efforts to improve cancer patient two-week referrals and performed better than the England average for people being seen within two weeks of an urgent GP referral. Between January 2017 to May 2018 96.9% patients were seen within two weeks against a standard of 93% and the England average of 93.2%.

Outpatients

- The services provided reflected the needs of the population served and ensured some flexibility, choice and continuity of care.
- Clinics were responsive to individual patients needs, and there were occasional weekend clinics, language aids, and a variety of seating.

Is the service well-led?

Requires improvement

We rated well led as requires improvement because:

- We were not assured that local governance arrangements were effective. For example; the low mandatory training compliance for fire safety and resuscitation, and lack of local audit such as clinic waiting times and late starts.
- We were not assured that local risk and performance was monitored appropriately. There was a lack of robust monitoring of infection prevention and control audits and checking of the paediatric resuscitation grab bag.
- There was a lack of recorded action plans to address concerns such as the declining referral to treatment times (RTT) and the patient tracking list. It was unclear what actions for quality improvement had been put in place or acknowledgement of the risk to patients.
- The trust did not engage well with patients, staff, the public and local organisations to plan and manage appropriate services. There was inconsistent feedback from staff about support from the trust senior executive team, and a general concern staff voices were not heard.
- There was poor visibility of executive level leadership with staff feeling disaffected by trust decisions.
- The service showed poor commitment to improving the quality of its services and safeguarding high standards as there was no audit programme for outpatients to improve performance and safety.
- The trust had a vision for what it wanted to achieve but there was no vision or strategy for the outpatients department developed with involvement from staff, patients, or key groups representing the local community.

However:

- Local managers within the outpatient departments promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

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

The trust's diagnostic imaging service is made up of a radiology department which includes the modalities X-ray, magnetic resonance imaging (MRI), computerised tomography (CT), nuclear medicine (NM) and ultrasound. Each modality has its own separate clinical area. The trust provides mammography in the breast unit and echocardiography in the cardio respiratory department as well as electroencephalogram (EEG) in the neurology department.

The trust provides diagnostic imaging to both inpatients, outpatient and the emergency department.

During our inspection we visited the radiology department, the neurology department, breast care and cardio respiratory departments. We spoke with 33 staff including managers, consultants, radiologists, allied health professionals (AHPs) such as; radiographers, mammographers, physiologists, sonographers along with clinical support workers (CSW) and secretarial staff. We spoke with nine patients and one relative and reviewed two patient diagnostic imaging requests along with relevant policies, meeting minutes and documents.

Summary of this service

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.

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:

- There was a potential risk of abuse to patients and staff as chaperones were not routinely offered or provided during intimate imaging procedures in the cardiorespiratory department and the ultrasound department. This was a breach of the Health and Social Care Act 2008 regulated activities regulations 2014 regulation 13: Safeguarding.
- Radiology staff did not meet the trust wide target of 95% compliance for adults and children safeguarding training. Radiology medical staff achieved 64% and allied health professional staff achieved 66%.
- Medical staff did not meet the trust wide target for mandatory training compliance (95%) in nine out of ten modules Including resuscitation training where only 50% of staff had completed the training.
- Allied health professional staff did not meet the trust wide target for mandatory training compliance (95%) in six out of ten modules including resuscitation training where only 67% of staff had received the training.
- Staff In the computerised tomography (CT) department referred to out of date protocols and protocols which applied to a decommissioned piece of equipment. This potentially compromised patient safety by staff using the equipment incorrectly. Staff did not have protocols to follow in the event of un escorted patients requiring contrast injections out of hours.

Diagnostic imaging

- Staff members in the radiology department did not consistently complete clinical room and equipment cleaning records appropriately to ensure cleaning procedures were completed.
- Ultrasound procedure rooms in the breast care unit did not have computer screens to enable consultants to review previous patient images whilst carrying out procedures. Consultants repeatedly had to leave the room to refer to previous patient images which meant the consultant had to work from memory.
- We were not assured staff looked after premises and equipment appropriately. There were inconsistencies with room cleaning and privacy curtain replacement record keeping in the radiology department and breast care unit.
- Staff across the radiology service did not follow National guidance in regard to 6-point patient identification check when patients attended for imaging procedures.
- We were concerned about the security of medicines in the breast care unit where staff stored personal medicines along with stock medicines. In nuclear medicine, medicine cupboard keys were not held securely but were available to all staff in the department.
- There was limited evidence managers shared feedback and learning from incidents consistently among wider teams.

However,

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff at the point of providing care.
- There had been no reported never events in the service between April 2017 and March 2018.

Is the service effective?

Not sufficient evidence to rate

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

- The service held Imaging Services Accreditation, (ISAS) and provided care and treatment based on national guidance and carried out audit to monitor the effectiveness. They compared local results with those of other services to learn from them.
- Staff of different specialisms 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.
- Staff in the breast care unit recorded verbal consent on a World Health Organisation (WHO) checklist for interventional radiology.

However,

Diagnostic imaging

- Staff In the computerised tomography (CT) department referred to protocols which applied to a decommissioned piece of equipment. Four other protocols we reviewed were out of review period. This meant staff did not have the most up to date and appropriate information available.
- Not all allied health professional staff had received an appraisal from their line manager. The service did not meet the trust wide target (90%) for staff appraisal (61%).

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 greeted patients by their name and introduced themselves. Staff asked patients what they prefer to be called.
- Staff protected patient dignity by drawing curtains around them, repositioning clothing or gowns and using blankets to cover them where possible during interventions.
- Staff enquired after patients' comfort and assisted them to change position if required before starting interventions.
- 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.

Is the service responsive?

Requires improvement

We rated responsive as requires improvement because:

- Services did not meet the needs of local people as patients were unable to access diagnostic imaging services in a timely manner.
- The service reported 47% of images within 24 hours which did not meet the reporting turnaround time target of 90% of images within 24 hours.
- The service did not display patient information in any other language than English throughout the departments we visited.
- There was no evidence of sharing and learning from complaints.
- The service had not been meeting the six weeks referral to treatment target (RTT) of 1% since December 2017 which peaked at 7.03% in April 2018. However, the trust attributed this to the commissioning of the Dexa service which had included a large backlog of patients. Performance data provided post inspection showed significant improvement with the 1% target being met in two of the three months between May and July 2018.

However,

Diagnostic imaging

- The service took account of patients' individual needs. Staff in magnetic resonance imaging (MRI) had created a picture book depicting the story of Jimmy the giraffe, a soft toy undergoing MRI. Staff showed the picture book to children and patients with learning difficulties to reassure them about the process and then gave them the giraffe toy to go through the scanner with them for comfort.
- Staff knew how to access a wide range of services to improve patient experience. For example, interpreters for those patients whose first language was not English, hearing loops, bariatric equipment, play specialists and dementia champions in order to meet the needs of patients.
- The service investigated complaints and concerns within the time frame.

Is the service well-led?

Requires improvement

We rated well led as requires improvement because:

- We were not assured the service had robust structures, processes and systems in place to support the delivery of high quality person centred care especially in the radiology department. This was because of the out of date protocols, the lack of oversight of cleaning records, poor compliance with mandatory training and safeguarding training, poor medicine security and lack of learning and sharing from incidents and complaints.
- Consulting staff in the breast unit did not manage patient information securely leaving patient identifiable information visible on computer screens when they left the room. This was a breach of the Health and Social Care Act 2008 regulated activities regulations 2014 regulation 17: Governance.
- Radiology staff found it difficult to attend team meetings due to shift patterns. There was little evidence to show that staff who had not attended the team meetings had received the information.
- The service did not actively engage with patients to improve services, surveys and feedback were ad hoc.
- None of the staff we spoke with were aware of the trust's freedom to speak up guardian.

However,

- The service had a vision for what it wanted to achieve around bringing reporting back inhouse and an informal strategy to turn it into action. For example, the trust was actively upskilling radiographers to report on images. Due to the national shortage of consultant radiologists the trust was upskilling three specialty doctors through the radiology academy.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Local leaders were visible, approachable and supportive to staff.
- The radiology department had a comprehensive audit programme to improve performance and safety. For example, X-ray exposure audits, peer reviews and request justification audits among many others.
- The service had effective systems for identifying risks, planning to eliminate them or reduce them.

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	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning services Maternity and midwifery services Nursing care Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Maternity and midwifery services Nursing care Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Family planning services

Maternity and midwifery services

Nursing care

Surgical procedures

Termination of pregnancies

Treatment of disease, disorder or injury

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures 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 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Maternity and midwifery services Nursing care Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning services Maternity and midwifery services Nursing care Surgical procedures	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour

This section is primarily information for the provider

Requirement notices

Termination of pregnancies

Treatment of disease, disorder or injury

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Our inspection team

The inspection was led by Tracey Wickington, Inspection Manager. Fiona Allinson, Head of Hospital Inspection, supported our inspection of well-led for the trust overall.

The team included 14 further Inspectors, one further Inspection Manager, CQC's National Professional Advisor for maternity, a representative from NHS Improvement, one executive reviewer, 12 specialist advisers, and one expert by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.